

14

children

NOVEMBER • DECEMBER 1960

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

THE UNIVERSITY
OF MICHIGAN

NOV 15 1960

PERIODICAL
READING ROOM

What Makes a Good Parent?

Trends in Infant Mortality

Mental Retardation in the USSR

Social Work in Medical Training



SE
par
bir
rel

children

®

VOLUME 7

NUMBER 6

NOVEMBER-DECEMBER 1960

What Makes a Good Parent? 207

Grace M. Heider

Current Trends in Infant Mortality 213

Alice D. Chenoweth and Eleanor P. Hunt

Mental Retardation in the Soviet Union 219

Joseph Wortis

**Emotional Problems of Children Facing Heart
Surgery 223**

Roberta Peay

Social Work Participation in Medical Training . 229

Lonis Liverman and Nathalie Kennedy

Book Notes 235

Here and There 236

In the Journals 242

Readers' Exchange 243

SECURITY. This picture expresses the quality of parent-child relationship that we like to think is the birthright of every child. But actually parent-child relationships vary not only from family to family, but

often even among parents and children within the same family. Some of the factors behind these variations have been under study at the Menninger Foundation and are discussed in the leading article in this issue.

With a research grant from the National Institute of Mental Health, psychologist Grace M. Heider is on leave from the Menninger Foundation, where for the past 10 years she has been studying normal children, and is working at the Psychological Institute at the University of Oslo, Norway. Dr. Heider is author, with Sibylle Escalona, of "Prediction and Outcome; A study in child development."



Before coming to the Children's Bureau 11 years ago, pediatrician Alice D. Chenoweth (left), was director of maternal and child health in the Kentucky State Department of Health. Dr. Eleanor P. Hunt, biostatistician (right), has been with the Bureau for 15 years. Previously she worked on studies of growth and development and of nutrition in the Department of Agriculture and the Public Health Service.



A 1948 graduate of the New York School of Social Work, Columbia University, Roberta Peay has worked in the South Carolina State Board of Health as medical social worker in a regional rheumatic fever and crippled children's program, in the Richmond (Va.) Health Department, and in the social service department of the University of California Medical Center, San Francisco. She has been with the National Institute of Mental Health for the past 5 years.



Joseph Wortis worked in psychiatry at Bellevue Hospital in New York, at Johns Hopkins Hospital in Baltimore, and at hospitals abroad, in addition to his work at the Jewish Hospital in Brooklyn. Author of the book, "Soviet Psychiatry," published in 1950, he has a grant from the National Institute of Mental Health for the translation and interpretation of Russian psychiatric literature.



Before taking her present position, Lonis Liverman (left) was medical social work consultant in the Long Beach (Calif.) Department of Public Health. Nathalie Kennedy (right) was director of social service at Children's Hospital of the East Bay, Oakland, Calif. Their social work degrees came from the University of Southern California and Fordham University, respectively.



◀ the authors

National Advisers to CHILDREN:

Luise K. Addiss, *nutrition*
 Barbara Biber, *education*
 John S. Bradway, *law*
 Inabel B. Lindsay, *social work*
 Reginald S. Lourie, *psychiatry*
 Margaret B. McFarland, *psychology*
 Robert E. L. Nesbitt, Jr., *obstetrics*
 Lloyd E. Ohlin, *sociology*
 Julius B. Richmond, *pediatrics*
 Reva Rubin, *nursing*
 William M. Schmidt, *maternal and child health*
 Earl Ubell, *communications*
 John Wallace, *corrections*
 Myrtle P. Wolff, *child welfare*

Editorial Advisory Board:

Mary E. Blake, *chairman*
Division of Juvenile Delinquency Service
 Katherine Bain
Office of the Chief
 Muriel W. Brown
Division of Research
 Jane W. Butler
Division of Social Services
 Sarah S. Deitrick
Division of International Cooperation
 James H. Scull
Division of Reports
 Helen M. Wallace
Division of Health Services

Editor:

Kathryn Close

Associate Editor:

Sarah L. Doran

Art Editor:

Philip Bonn

*Some observations from a child development
study inquiring into the question . . .*

WHAT MAKES A GOOD PARENT?

GRACE M. HEIDER, Ph. D.

Research Psychologist, The Coping Project, The Menninger Foundation, Topeka, Kans.

A STUDY of child development raises the question, "What is a good parent—what kind of person provides a growth-fostering background for his child?" To ask this question is to be faced with the fact that there are no simple answers. In each case, what we are observing is not merely a parent but a parent as he affects a particular child. We are soon aware that we are dealing with a circular process: The way a parent affects a child is influenced by what the child does to the parent.

A cuddly baby may be highly gratifying to a mother who finds pleasure in a warm and nurturant relationship; a baby with sensitive skin who is uncomfortable in close physical contact may leave the same mother frustrated and impede her ability to offer the kinds of contact he would enjoy. Moreover, the impact of parent and child on each other may change as the child moves from the dependence of infancy into the motility of the preschool years.

This article will present some of the factors in parent-child relationships that have been taken into account in a recent study of child development and will show how the picture changes when the factors are applied to the same children at preschool and early school ages.¹

The subjects of this study were 31 children who had been seen by research workers as infants and again at later ages in connection with two projects conducted in Topeka, Kans., during the last 13 years. The first of these projects, known as the infancy study, directed by Sibylle Escalona, Ph. D., and

Mary Leitch, M.D.,² between 1947 and 1951, included 128 infants and their mothers. The second, known as the coping project, directed by Lois B. Murphy, Ph. D.,³ was begun in 1952 and continued through the summer of 1960 with 31 of the children—27 mothers—who had taken part in the infancy study. Because each study included several pairs of siblings, there were fewer mothers than children. Both projects were carried on under the auspices of the Menninger Foundation and were largely supported by the National Institute of Mental Health, U.S. Department of Health, Education, and Welfare.

Relationships in Infancy

In most of the families in the infancy study the mother had the direct responsibility for the child's care, the father having an effect on the child principally as his feelings and attitudes made it easier or harder for the mother to assume her role with the baby. The factors that have been used to judge the relationship of the mother to the baby fall under four headings: (1) those that refer primarily to what was observed and what the mother told about her interaction with the baby; (2) those that refer in a broader sense to the personal characteristics of the mother; (3) those that refer to the relationship between the parents; (4) those that refer to the mother's relationship with the larger family unit of grandparents and other relatives.

These factors cannot be regarded as an exhaustive list of what is important for the mother-baby rela-

tionship, but only as relevant points for making fairly clear-cut judgments of the material on the mother-child relationships that had been described. Nor can these factors be regarded as independent units that can be counted like so many coins to reach a sum. Rather, they should be viewed in relation to each other in a total picture of the attitudes of each mother and child toward each other, which can then be assessed within the group.

With one child a high or low rating on a particular item may decisively affect the whole balance; with another the same item may have relatively little influence. Just as the same quality in the environment, such as a noisy house, may be a source of considerable stress to a child who is especially sensitive to sound, a source of enjoyment to another child, and a matter of indifference to a third, so the same quality in the mother can affect different children in different ways, and the nature of the effect can only be known by an examination of the overall picture.

1. Items referring to the mother-child interaction

Awareness of the baby's needs. The mothers differed in the extent to which they seemed aware of the baby's momentary states and needs. Sheila's mother, for example, shifted the baby's position whenever she herself became restless, regardless of whether the baby might just have settled comfortably for a nap after a period of restlessness. Diane's mother, seemingly unaware of the fact that Diane was a child who enjoyed rather energetic bodily movement, constantly handled her in a way that restrained her limbs. Chester's mother, on the other hand, seemed to attune her own actions to those of the baby, just as one partner in a dance adapts his steps to those of another.

Mother-child compatibility. This term describes a basic physiological and temperamental compatibility between mother and infant. It refers to the extent to which a particular mother and a particular baby seem to meet each other's needs. The importance of this factor should modify a too-ready belief that there is a single, ideal style of mothering against which each case can be measured. It is, for instance, usually assumed that the mother who is sensitive to each nuance of the baby's behavior will handle her baby better than the mother who lacks this fine sensitivity. Yet among the babies we observed there were some in whom a certain kind of compatibility

with their mothers seemed more important than sensitivity per se.

There was, for example, Lennie, whose mother, when he was 4 weeks old, showed a kind of "toughness" in handling him. Lennie was a sturdy, well-knit baby who fully satisfied his mother's desire for a boy, and she seemed to take pleasure in offering him a little less support than many mothers would have given a baby of that age. The two of them seemed to "understand" each other, and this understanding may have made for a sounder relationship than mere sensitivity.

On the other hand, Tommy, at 32 weeks, and his mother were less suited to each other. The mother was everything that our usual stereotype of the ideal mother includes—gentle, sensitive, and tender. But Tommy was an active, energetic baby who liked loud noises and apparently enjoyed the ordinary bumps that came his way. He seemed to demand rougher treatment than his mother gave naturally.

Lennie apparently was the kind of baby in whom his mother could find special pleasure and satisfaction, while Tommy's mother probably felt the need for a softer responsiveness than Tommy could give.

Degree of respect for the baby's autonomy. Some mothers appeared to understand the baby's moods and needs, and yet tried to make the baby do what they "knew" was best, for example, to go to sleep in a certain position or eat a certain amount. Other mothers used their awareness of the baby's individuality to let the baby take the lead. This difference was evident in the mother's attitudes toward their babies' schedules, toward toilet training, and toward food likes and dislikes, as well as in the way they handled their babies.

Acceptance of the baby's own developmental plan. Related to a tendency toward coercion in general was the attitude of the mother who had "read the book" or observed her neighbor's baby and who "knew" how fast her baby should be developing in each area. Other mothers were more relaxed about their babies.

Degree of acceptance of the infant. There were no mothers in the coping study who openly rejected their children and few among the 120 of the infancy study. Willingness to participate in such projects is in itself an indication of interest in the child and in that sense a selective factor. Nevertheless, differences existed in the degree of acceptance within the group. The way a mother held her baby, changes in

voice and expression as she approached him, and similar actions often gave clues to her feelings about her baby. Beyond this, the way mothers said what they said about their babies often conveyed more than their actual words.

A mother's feeling about the sex of her baby was sometimes a useful clue to her feeling about him. Gordon's petite, feminine mother expressed satisfaction with her very masculine baby, yet she treated him much as she would have treated the little girl for whom she had hoped. Lennie's mother, on the other hand, said that she and her husband had wanted a boy so much that they hardly dared admit it.

The kind and amount of contact offered to the baby by the mother. At home every mother necessarily spends some time away from her baby, the amounts of time varying with the mother and the circumstances. Differences between mothers in the amount of contact that they offered the baby during the 4-hour sessions in our study, when the baby was in a strange place and under observation by strangers, often seemed significant. For example, some mothers maintained constant physical contact, touching the baby when they were not actually holding him. Some kept their eyes on the baby or talked to him. Some, who did not keep up an actual contact in this way, remained in the part of the room where the baby was, obviously aware of him all of the time. Others went to the other end of the room and lost contact entirely during part of the session.

It seemed likely that most of the mothers who felt a need for constant physical contact with their infants as well as the ones who could separate themselves entirely from them were not altogether comfortable in their relationship with their babies.

The mother's idea of what the baby should be. Some mothers were able to sit back and watch the pattern that unfolded as the baby developed, offering support and guidance only where the baby seemed to need it. Other mothers tried to impose a pattern of their own on the child. Their success depended on a number of factors, including the strength of the mother's effort, the child's docility in the face of her pressures, and the consistency of mother's approach.

We find a variety of pictures among the cases in which the mother attempted to impose a pattern on the child. Ronnie and Greg both had mothers who wanted their babies to be "real boys," but even in infancy this pattern fitted Ronnie better than it fitted Greg. Gordon, since fate had made him a boy rather

than the girl for whom his mother had hoped, had at least to be "cute" and "smart." Darlene had to be "good" to conform to the strict religious outlook of her family. Donald had to be both "good" and "smart" to meet the demands of a family that showed the stress of high upward mobility coupled with conservative religious leanings. Daryl, whose decorative mother had especially welcomed a little girl, had to be "pretty" and wear her clothes effectively, even at 28 weeks. The demands of Roddie's mother for a "real boy" who was also a model of deportment suggested confused values, common in our culture.

2. Items referring specifically to the functioning of the mother.

Another series of items used in judging the mother's relation to the child deals with the question, "What kind of person is this mother?"

Level of adjustment. The psychologists and psychiatrists on the basis of personal interviews made judgments about each mother's general stability. In several cases the mother was regarded as a person who might experience a psychotic break at some later time. In others the impression was of a robustly healthy personality. Most cases, of course, fell at some point between these extremes.

The mother's feeling about her own competence in handling the baby. This item told something about the mother's relationship with her baby, but still more about the way in which she appraised herself.

Degree of acceptance of bodily functions in general. Some mothers found it difficult to deal with the physical side of life in any area, while others were matter-of-fact about it. This factor was observed from the way a mother behaved when she had to change a soiled diaper, when she came within range of an unexpected spray of urine, or when she nursed her baby in a strange place. It was also inferred from what she said and did in less stressful situations.

The mother's attitude toward breast feeding. This item overlaps the previous one but includes greater detail about the mother's attitude toward breast feeding. It is concerned with the mother's decision as to breast feeding, the reasons she gave for arriving at this decision, and observations concerning her feelings in this connection. Some mothers expressed an almost euphoric enthusiasm about nursing their

babies, others a matter-of-fact, comfortable satisfaction, and still others embarrassment or repugnance. The mother who was serenely able to put her baby on a bottle when she did not want to nurse him was probably making her child more comfortable than the mother who reluctantly carried out her doctor's orders for breast feeding.

3. Items referring to the relationship between the parents.

Less information was obtained about fathers and the relationship between the parents than about the mother and the baby. Nevertheless, there were a few items for which clues to the parents' relationship were available in many cases.

Temperamental compatibility of the parents. In many cases something could be inferred about this from what the mother said—or did not say, as when she seemed to avoid speaking of her husband.

Agreement in wishes about the baby's sex. Close agreement or sharp disagreement among parents in their wishes for a boy or a girl often gave a clue to their relationship with one another. Gordon's father had wanted a boy as definitely as his wife had wanted a girl. The mothers of Molly and Susan had hoped for the boys their husbands wanted, although neither woman had strong personal preferences. Other mothers had shared their husbands' deep satisfaction that their first child was a son.

Agreement on handling and disciplining the baby. Since in most cases the methods of child care are regarded as the mother's province as long as the child is a baby, the failure of the father to play an active role did not seem significant. All the more notable, therefore, were exceptions, as in the family of Joanne whose mother reported that her husband disapproved of the way she managed the baby's schedule and felt that she was spoiling the child.

4. Items referring to the mother's relationship to a larger family unit.

This group of factors entered the picture only if members of a larger family unit lived in the vicinity of the baby's family. It included a number of items:

The amount of help given by the family to the mother. Chester's aunts and his grandmother were always at hand to be called on when difficulties arose. Ronnie's mother accepted help that was offered, but

she would not have asked for it. Rachel's mother received help from her sister, but only in a major emergency. Janice's mother depended largely on her own resources and those of her husband.

Attitude of the mother toward the larger family group. Patsy's mother took for granted the considerable help given by her mother and sisters. Daryl's mother had help thrust upon her while Sally's mother had the task of giving eager grandparents on the two sides equal opportunity to participate in the life of the family. Teddy's mother made use of the services of essentially uncongenial and critical relatives-in-law, part of the time paying for them.

Preschool and Early School Ages

In using this schedule with children who are somewhat beyond the age of infancy we find that many factors now affect the child directly which, at the earlier age, reached the child chiefly through their effect on the mother. The child past infancy understands a good deal of what goes on between his parents and how they feel about each other. The father, with his personality characteristics and behavior patterns; the siblings, with their relationships to parents and to each other; and other relatives, with their various roles, enter the picture in their own right. The child now lives in a world that includes possessions of his own, his home, neighborhood, and community. The role and status of his parents in this broader world begin to affect his relationship to his parents and theirs to him.

By this time too the child himself has become a person whose behavior extends further and reaches deeper than the infant's. He is at an age when new possibilities exist in addition to accepting, enjoying, ignoring, or rejecting another person, as a baby can. For example, he may begin to want something just because another person has it, not just for its own sake. More clearly differentiated feelings such as hostility, guilt, or a desire to protect begin to affect his relationships with other people. His life space now includes past and future as well as present. It includes what is absent as well as what is at hand, what is thought and imagined as well as what is objectively seen.

Beyond all these extensions in his psychological world and in his feelings, the child experiences changes in what he can do *in* and *to* environment. Our records show that even a 4-week-old child can do something toward shaping his environment for his own comfort. He can turn his head to avoid

food, or push at a blanket that comes up against his face, or squirm until he has made himself a more comfortable nest in his bassinet. The preschool child has become more mobile. He can move about, speak, and act in ways that go much further toward shaping his world.

Some Findings

Many of the factors, such as the parent's acceptance of the child and satisfaction with what he was, seemed highly important to parent-child relationships. The parent's awareness of the child's needs and of what was going on with him was another such factor. Karen's mother, who by the time Karen was in school was busy with a family of seven children, gave a picture of Karen's world that contrasted sharply with the one Karen herself gave to the project's psychiatrist. Patsy's mother showed deep empathy with Patsy's moods, yet she often failed to recognize what was troubling the child. Molly's mother, on the other hand, seemed to know very well what lay back of changes in Molly's behavior.

In some cases, a parent seemed to understand a child's problems and yet be unable to accommodate his own attitudes in a way that would relieve the child. This was true of Darlene's parents who realized that their own religious and moral feelings created a gulf between their child and the community, and yet could do little to help her.

Pressures and Resistance

The schedule used to evaluate family background included several items dealing with the mother's respect for the child's own individuality and bodily autonomy. Most of the children showed a certain degree of resistance to external pressures—some even in infancy and some not until later.

Diane, at 28 weeks, seemed to resent her mother's insensitive handling. By the time Diane was 4, her mother had become a more relaxed person. Observers then found Diane to be an easy, comfortable child, but they were not surprised that she was able to hold her own—for example, when an adult asked her questions that she did not choose to answer.

In contrast, Janice in infancy appeared to be a highly docile, plastic baby in the hands of a kind but rather coercive mother who "knew" exactly what her baby should do every moment and what should be offered to her. By the time Janice was 5, her mother's tension had increased. Resistance, which had been minimal at 28 weeks, had become a focus

of the child's behavior, and mother-daughter conflict often reached uncomfortably high levels.

When Steve was a baby his mother seemed more interested in her own physical state than responsive to indications of the child's needs. When he was 5, she would pick him up and practically "pour" him into a snowsuit. Steve himself offered little resistance to such handling at either age, but he showed a high degree of motor tension as a baby and later.

Much of our data seems to justify the generalization that it is undesirable for a parent to impose a pattern on a child. Even when the pattern is congruent with the child's own direction of growth and the pressure is not severe, the imposition may impair the child's ability to handle his own life. When demands run counter to the child's natural pattern, they may restrict important areas of development. And they often contribute, as they seemed to with Janice, to a high degree of overt conflict, or as with Steve, to inner stress that affected both physical and psychological functioning.

Yet our data could not be interpreted unequivocally, even in regard to factors as evident as parental coercion. In the infancy study the mothers who were themselves systematic persons were sometimes happier and, therefore, better able to respond to their babies in general if the baby was on a schedule. A baby who had reached a crisis of fatigue in which he seemed unable to regain control was sometimes helped, for the moment at least, if his mother held him firmly in a position in which he was apt to fall asleep.

Obviously the way in which procedures were carried out was important. A mother could sometimes work out a schedule for her baby that involved a minimum of coercion; and a baby could sometimes be led by easy stages into falling asleep. But sometimes one saw fairly strong pressures exerted on a baby, and in individual cases it was not always clear whether or not this coercive treatment was undesirable.

The same generalization about the effects of parental pressures could be made in regard to the children at later ages, with the same questions holding even more significance. Greg's parents, for example, valued good grades and tidy homework—things that were relatively unimportant in Greg's creative, artistic approach to life. The parents were fairly successful in getting him to fall in with their pattern, and it was impossible to say how far, in the long run, this was going to be good or bad for this particular child.

It seemed unlikely that Greg's parents could

change their own basic outlook. They formed the major part of the child's setting and their approval was an important factor in his development. More than that, he lived in a world that would make demands very much like those they were making. A certain degree of compliance with the pressures that were exerted at home would make it easier for him to get on in this world. At the same time, he was being molded to an uncongenial pattern at a cost to other abilities that would have been satisfying to him and also might have produced a contribution to society. Greg, in this sense, poses a major question.

With another child, the parental pressure had different implications. Susan had suffered a severe attack of polio at the age of 3. Her own strong drive carried her a long way toward recovery, but unless her parents had enforced strong demands on her, her recovery would have been far less adequate than it was and she would have remained more seriously crippled than she did.

Compatibility

The item on parent-child compatibility raised new issues as the child grew older. The effects of incompatibility were striking in the case of Vernon, a socially sensitive, complicated baby who did unusually well on infant tests. Vernon belonged in a sports-oriented family that had little regard for individual feelings and little interest in the intellectual side of life. At the age of 4, he had one of the highest IQ's in the group, yet at 8 he was doing only mediocre work in school. The fact that he was liked by his peers and successful in elementary school games suggested a good adjustment; but the meaning to him and to others of his failure to use his resources in other areas remains an unanswered question.

The factor of compatibility introduced a somewhat different complication with Martin. When he was 28 weeks old he and his gay, very verbal, and very

charming mother made a delightful pair. The mother's sensitivity to her baby's changing moods did much to shelter him from what might otherwise have been the too-heavy impact of an ordinary environment. Yet, by the time Martin was 5, this very compatibility had intensified strains which he was finding hard to handle. He was competing with his somewhat more phlegmatic brother for his father's attention and at the same time suffering from guilt feelings toward the brother because of the easy victories that his own alertness and his mother's ready support brought him.

Tommy, at 32 weeks, had seemed to need more robust treatment than his gentle mother could offer him. As an older child he found his way into a strenuous little-boy life and an identification with his father that provided a pattern, both for his own very masculine interests and for a comfortable, flirtatious relationship with his mother. He apparently had reached this solution at considerable emotional and intellectual cost during his preschool years, but it seemed to have become established on a firm basis by the time he was in the fourth grade.

The results of this study are evidence of the importance of some factors affecting relationships between children and their parents. At the same time they show the difficulties involved in any attempt to designate a particular list of factors as good or bad as far as a particular child is concerned. Each factor must be considered in terms of the characteristics of both parent and child, and interactions between the child and his world must be taken into account in making any evaluation.

¹ Heider, G. M.: A pilot study of vulnerability to stress in infants and young children. 1959. (Unpublished doctoral dissertation, Library of the University of Kansas.)

² Escalona, S.; Leitch, M. E.; et al. Earliest phases of personality development. Child Research Monograph No. 17, Child Development Publications, Evanston, Ill., 1953.

³ Murphy, Lois Barclay: Learning how children cope with problems. *Children*, July-August 1957.

It takes youngsters a long time to grow up. Rather than attempt to make adults out of them, just be happy and content to make an adult out of yourself.

Byron O. Hughes, Professor of Child Development, University of Michigan.

CURRENT TRENDS IN INFANT MORTALITY

ALICE D. CHENOWETH, M.D.

*Chief, Program Services Branch
Division of Health Services*

ELEANOR P. HUNT, Ph.D.

*Assistant Chief, Program Analysis Branch
Division of Research*

Children's Bureau

AFTER TWO DECADES of declining rates, infant mortality in the United States rose from a record low of 26.0 deaths under 1 year per 1,000 live births in 1956 to 26.3 in 1957, to 27.1 in 1958.* Not since 1953-54 has a rate as high as 27.1 prevailed nationally. Provisional rates in 1959, and in the first 6 months of 1960, showed some decrease from the high levels of 1957 and 1958. Nevertheless, these rates—26.4 for 1959 and 25.9 for the first half of 1960—suggest that infant mortality is still elevated. They are considerably above levels to be expected on the basis of the generally downward trend in rate over the years 1950-57.

Reactions to this lack of progress in reducing infant mortality have varied from surprise to disbelief to a healthy skepticism regarding vital statistics. These have led us to examine available facts critically. In doing so we have become increasingly aware of the need for special State and local studies to follow up leads, not only from vital-records data, but from other community-wide sources of information as well.

During 1950-57 the annual reduction in rate on the average was 1.7 percent. Figure 1 projects the trend established in those years to 1958, 1959, and 1960.

The comparison of the recorded rate with the projected average level indicates that in 1958 the infant mortality rate was some 7 percent higher; in 1959, 6 percent higher; and in 1960 (January-June) about equally so. On a 12-month basis for 1960 an excess, perhaps not so large, is likely.

Thus a gap, though a narrower one, remains in 1958-60 between prevailing infant mortality levels and the lower levels which would be consistent with the 1950-57 trend. The excess in rate in 1958 meant a loss of 18 additional infants per 10,000 live births; and in 1959, a loss of 15.

The excesses of infant mortality in the past 3 years over projected levels were larger in the postneonatal period (1-11 months) than in the neonatal period (under 28 days). The provisional neonatal and postneonatal rates for 1960, shown in the table on page 217, are based on data for the first 5 months. Even when data are available for the 12 months of 1960, it seems likely that excess postneonatal mortality may be nearer 10 percent than the 23 percent shown in the table.

Neonatal mortality, on the basis of the same type of evidence, approximates in 1960 a level consistent with the trend during 1950-57. If confirmed by final figures for 1960 the elevation of neonatal mortality might be regarded as eliminated. The 1.1 percent decrease in rate annually between 1950 and 1957 represents the smallest relative reduction in rate in any period of comparable length since 1936.

*The source of birth and death data in this report is the National Office of Vital Statistics.

Widening differences in neonatal risks between white and nonwhite infants, and substantial differences among the several States, and between newborn in metropolitan and in other counties represent potentialities for reducing the neonatal death rate.

Impact on Infant Population

In order to plan measures to promote more rapid reduction of infant mortality, identification of the groups of infants for whom risks are high is essential. Some clues are available from vital-records data of recent years.

Among infants less than a day old, reduction in mortality rate during 1950-57 was insignificant, though relatively large decreases in the rate were made from 1943 to 1950 (12.1 percent in toto) and from 1936 to 1943 (23.2 percent in toto). The mortality rate for nonwhite infants less than a day old increased during 1950-57 by 1.4 percent annually, the rise becoming evident as early as 1952.

The death rates for infants of 1 week to 3 months of age also dropped more slowly during 1950-57 than in previous periods. For infants of 1 to 3 weeks of age (7-27 days) the decrease in rate between 1950 and 1957 was 8 percent, as compared with 45 percent between 1943 and 1950; for those of 1 month to 3 months the drop was 10 percent between 1950 and 1957, but 41 percent from 1943 to 1950. In the latter age group, in 1958, the rate—4.2 deaths per 1,000 live births—was 14 percent higher than the rate to be expected from the trend for that age group during 1950-57, a 2 percent decrease in rate annually.

The nonwhite group showed much less improvement than the white group, although nonwhites had a higher mortality rate to begin with and so greater room for improvement. In fact, among nonwhite infants 1 week to 3 months of age no clearly defined trend of reduction during 1950-57 was evident.

During this period about 38 percent of infant deaths occurred on the first day of life, and nearly 1 in 4 at ages 1 week to 3 months. Thus about 3 out of 5 infant deaths occurred at the ages in which there had been marked slowing down of the decrease in infant mortality. The fact that in these early age groups, in which the large proportion of infant deaths occurred, the death rates have failed to decline at the same pace as previously has had a strong deterrent effect in the overall reduction of infant mortality.

Reduction in mortality of infants of all ages in metropolitan counties during 1950-57 has been half

as rapid as among infants in nonmetropolitan counties, 1.3 percent decrease annually as compared with 2.7 percent. Nonwhite infants in metropolitan counties for whom the infant death rate was 66 percent higher than for white infants in 1950 and 92 percent higher in 1958 showed no decrease in mortality during 1950-57, the rate remaining in the neighborhood of 40 deaths per 1,000 live births. In the nonmetropolitan counties, mortality rates for nonwhite infants were even higher and showed only slight and doubtful improvement.

In 1958 State infant mortality rates ranged from a low of 21.3 per 1,000 live births in Rhode Island to 41.0 in Mississippi. Rhode Island also had the lowest neonatal mortality rate, 15.7, while the maximum rate of 30.2 was recorded for the District of Columbia. For the United States as a whole, infant mortality was 27.1 and neonatal mortality was 19.5.

State differences were wider in the case of mortality of infants 1-11 months of age. The lowest post-neonatal rate, 4.9 per 1,000, was for Connecticut; the highest, 16.1 in Mississippi. Still higher rates were recorded for the Virgin Islands, 20.4, and Puerto Rico, 26.9.

Causes of Death

The tabulated causes of deaths give some help in understanding recent trends in infant mortality, since they identify to some extent the morbidity groups with stationary or rising death rates.

About two-thirds of all infant deaths are from prenatal and natal causes, which include conditions such as immaturity, postnatal asphyxia and atelectasis (imperfect expansion of lung at birth), congenital malformations, birth injury, and certain other conditions, including hyaline membrane. Ninety percent of the deaths attributed to these cause categories occur in the first month of life; about two out of three of these are of prematurely born infants. Progress in decreasing the death rate for these causes has been much slower than for postnatal causes. Between the periods 1950-53 and 1954-57 the rate for prenatal and natal causes, 18.6 per 1,000 live births, was reduced only 4.3 percent, while for postnatal causes the reduction in rate was 10.3 percent—from 6.8 to 6.1. Among nonwhite infants the rate for prenatal and natal causes increased slightly, from 22.5 to 22.7.

While in general during 1950-57 decrease occurred in infant mortality from postnatal causes—such as certain infectious and parasitic diseases, diseases of the digestive system, and accidents—death rates

from infections of unidentified types showed small but continuing increases. (See figure 2.) These included: pneumonia of the newborn, which increased in rate per 100,000 live births 5 percent between the periods 1950-1953 and 1954-1957, primarily in the nonwhite group; acute upper respiratory infection, bronchitis, and related infections, which increased 6 percent; meningitis, except meningococcal and tuberculous, 5 percent; "other infections of the newborn," 53 percent; and septicemia and pyemia, 48 percent. Jointly these infections during 1950-53 accounted for 5,159 deaths annually, or 137 per 100,000 live births. During 1954-57 the annual toll increased to 6,248 infant deaths, or 152 per 100,000 live births. Had the death rate for these causes decreased at about the pace of the death rate for infectious and parasitic diseases as a whole, the lives of approximately 2,500 infants annually in 1954-57 would have been spared.

Hypotheses for Study

While we know something about the ages at which infants have been dying, the places where they have been dying, and the chief causes of death, we need to know much more before we can outline a control program. State and local studies are needed in which clinico-pathologic data, collected and evaluated by medical committees, and vital records data can be correlated with information about the mother's health, the family's level of living, and the medical services provided to the mother and infant.

Some of the questions needing answers are:

To what extent is the rather stationary rate on the first day of life during the 1950's a result of more nearly complete birth and death registration, particularly of very small infants?

To what extent is the rising death rate of the first day for the nonwhite group related to an increase in incidence of prematurity?

While prematurity among white infants decreased during the 1950's from 7.2 percent to 6.8 percent in 1958, it apparently increased in the nonwhite group from 10.4 percent in 1950 to 12.9 percent in 1958.

During 1950-58 nearly a million nonwhite persons left the South, going particularly to industrial and commercial centers in other geographic areas. In general this migration had the effect of increasing hospitalization for delivery, and perhaps of adding

CURRENT EXCESS IN INFANT MORTALITY

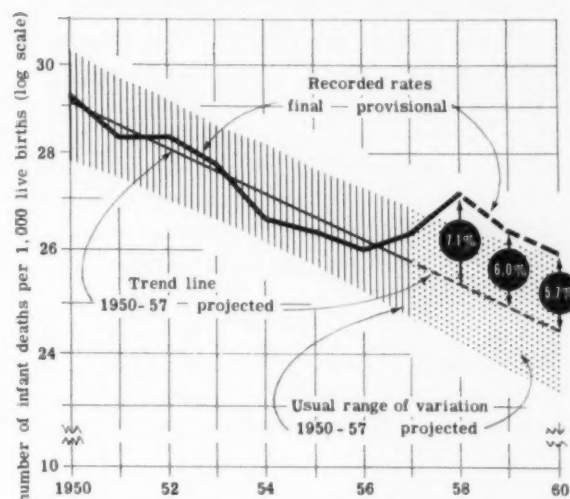


Figure 1

The recorded rates in this chart are based on registered live births and deaths. The trend line, estimated from the recorded rates during 1950-57, shows the annual decrease in rate, 1.7 percent. Rate values beyond the usual range of variations would probably occur less often than once in 20 trials.

to the completeness of registration of infant deaths and premature births, providing truer, though higher, estimates of mortality.

Data from the District of Columbia illustrate the effects in large cities of changes in population since 1950. Though the metropolitan area has grown by one-half million since 1950, the central city contributed only 5,000 to that increase. Though the proportion of white to nonwhite births changed little in the entire metropolitan area—about 3 percent increase in nonwhite births between 1950 and 1957—the picture was entirely different in the core city, where among residents, white births dropped from 56 percent to 35 percent and nonwhite births rose from 44 percent to 65 percent. In suburbia the percentage of white births rose from 90 percent to 92 percent; the nonwhite dropped from 10 percent to 8 percent.¹

What proportion of premature births and of infant deaths are associated with lack of prenatal care?

Again the District of Columbia provides an example. In 1952, 30 percent of the births at the D.C. General Hospital, the public hospital, were without prenatal care; by 1956 the percentage without prenatal care had risen to 47 percent and it

remained at that level in 1957 and 1958. Of the women delivered at the D.C. General Hospital in 1956, the neonatal mortality for those without prenatal care was 41.6. (In the District as a whole in 1956 it was 23.9 for the total population; for the nonwhite population, 28.9.) In 1957, when 12.2 percent of the births at the hospital were premature, 21.5 percent of the mothers who had not had prenatal care gave birth to premature babies, as compared with 10.2 percent of the mothers who had had prenatal care.¹

What has been the effect on infant mortality of the one-third increase in number of infants born out of wedlock in the United States—from 141,600 in 1950 to 208,700 in 1958?

What part, if any, of the increased mortality from "other infections of the newborn", septicemia and pyemia, and several other categories of infection of undefined etiology, is associated with hospital-acquired staphylococcal disease?

What part, if any, did inadequacy of facilities and manpower for maternity care play in the infant mortality rates?

This last question seems especially relevant since the great majority of births today take place in hospitals—98.2 percent of white births and 81.1 percent of nonwhite births in 1957.

Data from the American Hospital Association show that since 1946 the number of births has increased faster than the number of hospital bassinets.² Since bassinets and maternity beds can be presumed to be about equal in numbers, does this mean that in the Nation as a whole there is a shortage of maternity beds? Or, since hospital stay has been shortened in recent years, has the slower increase in beds been sufficient? Have hospital stays in maternity cases, perhaps, become too short?

Between 1946 and 1957 the stay for all patients in general hospitals decreased from an average of 9.1 to 7.6 days, reflecting recent scientific advances in medicine and more specific and more intensive therapy. For maternity patients the average length of stay in 1957 was even shorter—4.5 days.³ In some large public hospitals the stay for some patients was as short as 24 to 48 hours. In such instances the lag in growth of facilities, lack of personnel, and high cost have probably worked together to shorten the stay in the hospital.

Adequacy of maternity beds depends also not only on total number of beds but on their distribution. With the rapid changes of population in central cities the maternity wards of many public hospitals in large cities are reported to be overcrowded, while the maternity census in central city private hospitals is going down and in suburban hospitals is rising.

Medical manpower has not kept pace with increasing births. Though the number of physicians in private practice is increasing, the population growth has been even greater, so that the ratio of physicians to population has been declining. In spite of the increase in filled internships, the disparity between the number of available intern positions and the number of graduates of American medical schools has been growing steadily larger each year.⁴

"Physicians for a Growing America," the report

INCREASES IN INFANT MORTALITY FROM INFECTIONS

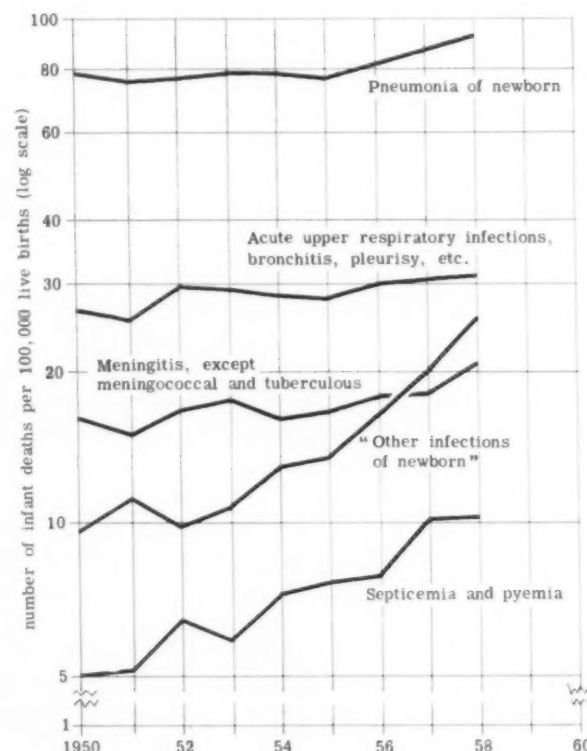


Figure 2

The causes shown here correspond to those of the International Statistical Classification of Diseases, Injuries, and Causes of Death. "Other infections of the newborn" are exclusive of pneumonia and diarrhea of the newborn.

INFANT DEATHS PER 1,000 LIVE BIRTHS

Neonatal

	1957	1958	1959	1960 (Jan.-May)
Percent excess of recorded over projected rate-----	+1.6%	+4.8%	+3.8%	+1.1%
Recorded rate-----	19.1	19.5	*19.1	*18.4
Projected rate assuming annual percentage reduction prevailing in 1950-57 (1.1%)-----	**18.8	18.6	18.4	18.2

Postneonatal

Percent excess of recorded over projected rate-----	+2.9%	+11.8%	+10.6%	+23.4%
Recorded rate-----	7.2	7.6	*7.3	*7.9
Projected rate assuming annual percentage reduction prevailing in 1950-57 (3.3%)-----	**7.0	6.8	6.6	6.4

*Provisional.

**Estimate of the expected rate in 1957 pursuant to trend, 1950-57.

of a consultant group on medical education to the Surgeon General of the Public Health Service, calls the maintenance of the present ratio of physicians to population "a minimum essential to protect the health of the people of the United States," and states that to achieve this the number of physicians graduated annually by schools of medicine and osteopathy must be increased from the present 7,400 a year to some 11,000 by 1975.⁵ In 1959 a total of 8,269 physicians were licensed to practice for the first time in the United States.⁶

What about nurses?

Though there was an 87 percent increase in the number of nurses employed by general hospitals between 1946 and 1959, the size of the increase is offset by the fact that in 1959 more than one-fifth of the professional nurses in general hospitals were part-time workers who were not likely to relieve the nursing shortage in some of the more critical personnel areas of the hospital such as the night shift in the nursery.⁷

The growth in the number of practical nurses and auxiliary workers in general hospitals has been more rapid than the increase in professional nurses. Whereas in 1946 the ratio of professional to non-professional nurses in general hospitals was about five to three, by 1959 the ratio was reversed in favor of the nonprofessional nursing staff to approximately one professional nurse to 1.1 practical nurse and auxiliary worker. One might seriously question

whether quality of care has been affected by this change in the nursing staff of hospitals.

Are community programs of services for mothers and infants adequate in coverage and in content?

Between 1950 and 1957 services under maternal and child health programs in the United States have increased some. The proportion of mothers receiving medical-clinic services rose from 48 per 1,000 live births to 56 per 1,000; the proportion of mothers receiving public health nursing services increased from 71 per 1,000 births to 104 per 1,000; the proportion of infants receiving nursing services changed little, from 143 per 1,000 to 156. Infants attending well-child conferences were about 80 per 1,000 in 1950; 127 per 1,000 in 1957. Service rates have increased some since 1957, but not enough to fully offset the rise in infant mortality. Should the growth of these services be speeded up? Are they increasing where they are most needed? Are additional types of services needed?

Central cities face especially difficult problems in financing needed public services not only for health, but also for welfare, housing, and education—all areas relevant to the survival and health of infants. Migration of low-income families into, and of middle-income families out of cities, has resulted in greater need for public services within the cities and a reduced tax base to support them.

District of Columbia material is again illustrative. In a board of trade study in 1958 the median income for suburbia was \$7,940; for the District, \$5,660; for the area as a whole, \$6,860. A study made by the Census Bureau for the District of Columbia in 1956 revealed 20.4 percent of families with income less than \$3,000 a year—11.6 percent of the white families, 31 percent of the nonwhite; 46.8 percent with incomes below \$5,000—30.8 percent of the white, 66.3 percent of the nonwhite.¹

For the past several years, according to birth certificate reports, only 40 percent of births to resident mothers in the District of Columbia were attended by private physicians while 60 percent were hospital staff cases. Although the number of births to residents changed little between 1950 and 1958, the number occurring at the city hospital increased by some 23 percent. In 1958 more than 30 percent of these births occurred in the city hospital. These births represented 4 percent of the white births and about 47 percent of the nonwhite births in the District.

With a decreasing ability to tax and an increasing need for public services and with the ratio of physicians to population declining, cities face a serious problem in attacking the weak spots behind the mortality figures. This calls for more efficient use of medical and nursing manpower.

But no matter how skilled physicians, nurses, and

other health workers are, they alone cannot speed the decline of infant mortality. Real progress will require the coordinated efforts of representatives of the fields of health, welfare, education, housing, and industry to improve conditions in families in which poor nutrition, poor housing, low levels of employment, and a large number of children combine to create a multiplicity of overwhelming problems.

¹ Oppenheimer, Ella: Population changes and perinatal mortality. (Paper presented at American Public Health Association, October 1959, to be published.)

² Hospital statistics; non-Federal short-term general and other special hospitals (tables 1 and 9). *Hospitals*, August 1, 1958 (part 2).

³ U.S. Department of Health, Education, and Welfare, Public Health Service: Health statistics from U.S. national health survey; hospitalization, patients discharged from short-stay hospitals, United States, July 1957-June 1958. Public Health Service Publication No. 584-B7 1959.

⁴ American Medical Association, Chicago: Number of physicians classified as to type of practice (table 3). In the American Medical Directory, 20th ed., 1958.

⁵ U.S. Department of Health, Education, and Welfare, Public Health Service: Physicians for a growing America; report of the Surgeon General's consultant group on medical education. Public Health Service Publication No. 709. 1959.

⁶ Fifty-eighth annual presentation of licensure statistics by the Council on Medical Education and Hospitals of the American Medical Association: Activities of the Federation of State Medical Boards of the United States. *Journal of the American Medical Association*, May 28, 1960.

⁷ Hospital statistics. *Hospitals*, August 1, 1960 (part 2).

In a society that is increasingly influenced by science and technology, and in a world that has become so small that events in the most remote parts of it affect us all, it is becoming more and more difficult for the individual to find his niche, to create with his own hands and mind, to be a person in his own right.

Children do not grow automatically into civilized and mature human beings; nor does the answer to mature adulthood lie in favorable surroundings alone. Individuals do not become civilized and mature without the opportunity for thought and reflection; they do not become great until they are first creative.

A major question for us all in these days of rapid and extensive change, therefore, is how we can make it possible for young people to think in a culture where there is much to discourage thought; how we can provide the opportunity for reflection in a culture that regards action as one of the main criteria of success; how we can insure creativity in the spiritual sense in a society that places so much importance on material possessions.

Leonard W. Mayo, Executive Director, Association for the Aid of Crippled Children, New York, to the 1960 White House Conference on Children and Youth.

MENTAL RETARDATION IN THE SOVIET UNION

JOSEPH WORTIS, M.D.

Director, Division of Pediatric Psychiatry, Jewish Hospital of Brooklyn, N.Y.

DURING a recent 7-week visit to the Soviet Union under a grant from the National Institute of Mental Health, U.S. Department of Health, Education, and Welfare, I had an opportunity to visit eight cities and to make a number of observations and inquiries on various aspects of child care and psychiatric practice. Because of my special interest in mental retardation I gathered as much information on this subject as I could, and supplemented it with further study of the Russian literature. Although my visit coincided with the summer vacation period, so that I could not observe the schools, I was able to learn enough to describe briefly the main features of Soviet work in respect to retardation.

In the Soviet Union, mental retardation is viewed basically in the same way it is viewed here: as a problem involving both biological equipment and educational opportunity. Human intelligence—or the lack of it—is not regarded as a simple matter of genetic endowment, but as a complex phenomenon, implicating inborn peculiarities of nervous structure or function, diffuse or focal brain damage, sensory or motor defects, fatigability, educational development, psychological interest or incentive, capacity for attentiveness, distractibility, and a number of other related factors. There are, however, important differences in approach and emphasis among Soviet psychologists and educators as compared with those in this country.

In the Soviet Union a child's performance on a series of standardized tests, such as we employ in psychometric examination, is not regarded as a measure of intellectual capacity. Prof. A. R. Luria, whom I met at the Moscow Institute of Defectology last summer, said to me:

An IQ of 65 might mean quite different things in four different children: the first might have a congenital brain defect; the second might be suffering from a general weakness of the

nervous system due to fatigue, general debility, malnutrition or some other weakening condition correctable later in life; the third might have some motor or sensory defect, such as a partial hearing loss; and the fourth might be a perfectly normal child who lost a lot of time at school because of some protracted illness. An IQ is always a merely quantitative thing; it tells us little or nothing about the qualitative causes of the bad performance.

For these reasons psychometric testing is not used in the Soviet Union. It is not now the basis for diagnosis of mental deficiency nor for special educational placement.

For a period after the October revolution of 1917 western psychometrics enjoyed considerable vogue in the Soviet Union, and both backward and gifted children were sorted out by the psychometricians, called pedologists, for special educational placement. It was soon discovered, however, that the gifted child tended to come from the displaced upper classes, while a disproportionately large number of the backward children came from workers' and peasants' families, or from certain undeveloped national groups. Many complaints and criticisms and much theoretical discussion ensued, leading finally in 1936 to a resolution of the Communist party castigating the psychometricians for labeling an excessive number of normal children as defective, abolishing the whole profession of pedology, and inviting the pedologists to become teachers if they wished.

One consequence of this sweeping resolution was to give the educational system back to the teachers—called pedagogues in the Soviet Union—and to elevate pedagogy to a level of a serious and systematic science. To this day almost all psychological work is conducted in pedagogical institutes and its reports are published in pedagogical journals. The leading research institute on mental retardation, the Moscow Institute of Defectology, comes under the aegis of the Academy of Pedagogical Sciences,



Children in a work-therapy session at the Bekterev Institute, a school for the mentally retarded near Leningrad.

which is the planning and coordinating agency for scientific educational work.

The Institute of Defectology is staffed by about 50 scientific workers, of whom some 10 or 15 are psychologists, seven or eight neuropsychiatrists, while 20 or more could be described as scientific pedagogues, whose work differs very little from that of the psychologists. There are only one or two pediatricians on the staff. This research institute is associated with a small school, which is used for training and research purposes, but its own activities are limited to research on the development of diagnostic, analytic, and teaching techniques for the educationally handicapped, including the retarded. Its current budget is 10 million rubles a year, a very large sum, when one considers that the salary of a skilled scientific worker may be 30,000 to 60,000 rubles a year, and that of a laboratory assistant 7,000 to 15,000 rubles.

Many research projects are being carried out at the Institute. They include a series of studies designed to correct faults in attentiveness associated with asthenia or fatigability or faults in plasticity. These studies and others reveal a concern for correctable *physiological* malfunctions of the brain—in contrast to the common assumption in this country that brain dysfunction necessarily means anatomical defect. Professor Eugene Sokolov, an associate of Professor Luria at the University of Moscow, is doing remarkable work in the measuring and recording of attentiveness by studying a number of physio-

logical variables, especially shifting changes in the caliber of the blood vessels of the scalp and fingers. By means of these methods it is now possible to record the response of children to words related by sounds or by meaning, and thus to study the steps through which language development proceeds in both normal and defective children. This has important implications for the analysis of the thinking processes and for corrective education. Professor Luria has for a long time been interested in the organizing role of speech in the development of thinking and of abstract concepts in children.

One result of research carried out at the Institute is the development of an ingenious pencil-shaped photoelectric scanning device that emits distinctive sounds when passed over printed letters, so that the blind can learn to read by ear.

Definition

Soviet workers in the area of retardation tend to narrow the field to those types of retardation presumed to be due to cerebral defects or inadequacies, and to regard types of intellectual or educational backwardness due to social, educational, or psychological causes as problems of general pedagogy. The preferred term for mental deficiency is oligophrenia, which has connotations of a medical nature. Dr. Pevsner, the author of a recent textbook on oligophrenia and a member of the Institute's staff has described it as "a kind of underdevelopment of the complex forms of mental activity which arises as a result of an organic lesion of the central nervous system at different stages of the intrauterine development of the fetus, or in the very early period of the child's life."

The diagnosis of oligophrenia, Dr. Pevsner told me, should be limited to those children who can be presumed to have suffered an actual brain injury in intrauterine, perinatal, or early infant life. She said it was reasonable to assume that the main pathological lesion in such cases was a diffuse injury or defect of the cortex, though she acknowledged that certain other associated factors may be encountered, mainly of two kinds: She said that hydrocephalus seemed to be a common associated factor in mental deficiency and that a superimposed focal lesion may complicate a diffuse brain injury.

Dr. Pevsner also expressed the opinion that the crucial physiological factor in the pathogenesis of mental deficiency was the inertness or immobility of the feeble-minded child's reactions. Acknowledging that the element of anatomical defect must be con-

sidered too, she said that this may well express itself by contributing to the physiological inertness or lack of plasticity, and hence to an incapacity to shift or modulate in the learning process. She pointed out that the mammalian brain, in its evolution, has constantly gained plasticity and that the lack of plasticity could be regarded as a lower evolutionary stage of brain development.

From a clinical point of view, a leading symptom among mental defectives is their lack of capacity for abstraction or conceptual generalization. Dr. Pevsner described three types in which the lack of plasticity could be encountered: (1) those having a weakened capacity for both excitation and inhibition; (2) those in which the inhibitory functions are weak—the restless or excited children; (3) those in which the excitatory processes are weak—the torpid, indolent children.

Special Education

Children having these various types of defects are not segregated according to type or diagnosis but are mingled in special schools. The Soviet pedagogues regard it as undesirable to have a school group consisting only of children with one type of symptom—hyperactivity, for instance. The teachers are instructed in the specific difficulties of each child and are then expected to individualize their understanding and approach to the educational problem the child presents.

For example, the hyperactive child is first taught inhibition by external restraint. A teacher may actually hold a hand over the child's mouth or restrain his mobility. At a later stage the child may be expected to impose his external restraint upon himself by clapping his own hand over his mouth, and still later the restraint may become internalized, an important gain for the child.

The proportion of boarding schools among these special facilities is high: in the Russian Federated Republic, out of 301 special schools, 130 are boarding schools. In Leningrad, three out of eight special schools are boarding schools.

The more severely retarded children—imbeciles and idiots—are dealt with outside the school system, in special hospitals and day centers. These are under the control of the Ministry of Social Welfare. I do not know how many children are so placed.

J. Tizard,¹ a British visitor to the U.S.S.R. a few years ago reported that the education of defective school children includes solid groundwork in reading, writing, and arithmetic, and elementary instruc-

tion in the natural sciences, geography, history, civics, drawing, singing, and physical education. During the last 5 years of training increasing emphasis is placed on vocational training. Tizard also reported that over 90 percent of the young people who complete special schools become employed in ordinary work. Prof. Zurabashvili and his staff in Tiflis told me that graduates of special schools go to work in regular factories or on collective or State farms, where special and appropriate tasks can be assigned to them. I unfortunately have no information on the number who fail to meet the curriculum requirements of these special schools, but I suspect their number is small.

Because of the Soviet distrust of psychometrics, and their special concern about the possibility of social and psychological reasons for retardation, children are ordinarily not placed in special education facilities for the retarded until they have spent a year in a normal class. The decision to transfer the student from the public school to an auxiliary school can be made only by a special commission, and only after it has been established that the public school has taken all necessary measures over an extended period of time to improve the child's success, without obtaining positive results; and after child psychiatrists have also concluded that the cause of the child's inability to pursue the public school studies is a mental deficiency due to an organic brain defect or disease. If there is no special school in the child's region or city the child may be sent to a school elsewhere. The regulations require that each student shall be accorded an annual review of his status by the pedagogical soviet of the school to determine the possibilities of his return to a regular public school.

There are no waiting lists for any of the special educational facilities, and all are fully staffed. Tizard describes a typical day school for 230 educationally subnormal children (all high grade defectives except for 20 imbeciles) which is generously staffed with teachers, and in addition had a physician and two feldshers (physician's assistants) in attendance. He also described a residential institution for 60 trainable, physically healthy imbecile children, aged 8 to 17, which had a staff of 32; and another larger one near Leningrad with 210 children (75 high grade imbeciles, 80 low grade imbeciles, and 55 idiots, including 23 cot cases) and a staff of 107.

There is much medical activity with these children, a great deal of it preventive in nature—frequent examinations, massage, exercise, special diets—as well as conventional medical treatment.

There is also some psychotherapy, speech therapy, and physiotherapy.

Teachers of the retarded get a special 5-year course of training in the defectology department of the teachers' training colleges. This is 1 to 2 years longer than the regular teacher training course. A regular teacher who wishes to work in this field must acquire additional training. Teachers of the retarded get 25 percent more than the regular teachers' salary of 800 to 1,100 rubles a month.

Incidence

Though statistically reliable comparisons are not possible, and will not be for some time, there are indications that the actual amount of true mental deficiency in the Soviet Union is less than it is in the United States.

The strict policies on admission to special schools, Professor Luria told us, are partly responsible for the low percentage of children in special classes, a proportion he estimated roughly as less than one percent. After further inquiry and investigation I made an estimate which I believe to be more accurate. The result is even lower. In the Russian Federation Republic, which has a population of 113,000,000, there are 30,000 children in special classes for defectives, and an estimated additional 18,000 mentally retarded children still in the regular school, not yet diagnosed or placed, making a total of about 48,000 children regarded as suitable for special classes. Since a little more than 16,000,000 children are now attending the 10-year schools (corresponding to our primary and secondary schools), this would mean that one child out of every 350 children of school age, or less than one-third of one percent, is regarded as suitable for placement in the special classes for the retarded. These figures include children in special boarding schools.

Even if these rough estimates were doubled to make allowance for children outside the school system, the proportions would be considerably lower than the usual estimate of mental retardation in our population—3 percent. But it is, of course, not possible to get an accurate idea of prevalence from the numbers receiving services.

It is interesting to conjecture whether the apparent low rate of mental retardation in the Soviet Union may bear some relationship to the fact that the Soviet population is given free and comprehensive medical service—much of it preventive—from the womb to the grave. This attentive medical care, associated with liberal maternity leave policies and benefits (4

months leave with full pay, starting with the 8th month of pregnancy), may contribute to the health of offspring.

For example, the amount of prematurity (based on a birth weight of 2,500 g. or less) in the city of Kiev is reported as 4.9 per 100, compared with an overall rate of 9.4 per 100 reported in the city of New York in 1959, and over 16 per 100 for the Negro population in some districts of the city. The prematurity rates in Kiev and New York may, of course, be based on dissimilar reporting methods or varying completeness, but the differences are probably real.

The so-called psychoprophylactic or natural method of childbirth, which is used in 90 percent of the births in the Soviet Union, minimizes the use of drugs and may reduce the chance of brain damage.

The Cesarean-section rate is said to be generally around 2 percent in Soviet obstetrical services, and is reported as above 4 percent in many hospitals here. The many children we saw all over the Soviet Union impressed us as being unusually vigorous and robust.

Conclusions

On the basis of my observations and studies, which were necessarily limited, I think I can fairly make the following general statements:

- The overall picture of mental retardation services and research in the Soviet Union compares favorably with our own, and is in some respects superior.

- The rejection of psychometric testing, the exclusion of social and psychological problems from the concept of oligophrenia, and—possibly—the comprehensive health services combine to reduce the incidence of diagnosed and recognized mental deficiency in the U.S.S.R. But valid statistical comparisons are difficult to achieve.

- Russian research in this field is more neurophysiological than is our own and tends to be more intimately related to educational practice.

- Vocational placement of the retarded adult seems to create no difficult problems in the Soviet Union.

- Special education is regarded as a branch of science. The teachers enjoy considerable social prestige.

Continued contacts between American and Soviet scientists and other professional persons, mutual interchange of information and personnel, and cooperative research undertakings promise to be mutually rewarding.

¹Tizard, J.: Children in the U.S.S.R.; work on mental and physical handicaps. *Lancet*, December 20, 1958.

THE EMOTIONAL PROBLEMS OF CHILDREN FACING HEART SURGERY

ROBERTA PEAY

Clinical Social Worker, Social Service Department, Clinical Center, National Institutes of Health

IN THE PAST DECADE spectacular developments in heart surgery have resulted in the hospitalization of numerous children having congenital heart disease.¹ Experience with these children has shown that, as in other illnesses, the chances or speed of the child's habilitation can be affected not only by his general physical condition and the medical skills applied to it, but also by the illness' byproducts—its psycho-social aspects—and the understanding of these by persons in contact with the child or his parents.

Because the heart is such a vital organ—with life depending on its continuous functioning—to learn that a child has "heart trouble," with which he was *born*, is usually an extremely frightening experience for both child and parents. Moreover, while the new surgical techniques hold out hope for complete recovery for some, and partial recovery for others, they are not a panacea nor are they undertaken without risk. Their very newness may hold a special terror for many parents. Such fear can affect both the child's and the parents' ability to cooperate with doctors, nurses, social workers, and others on a hospital or clinic staff who are trying to help them. When the staff understands these feelings and other factors in the patient's or family's life that are entangled with their attitudes toward the child's condition, the psycho-social impediments to the child's recovery can be dealt with.

We see many of these children at the clinical center of the National Institutes of Health, the clinical research arm of the United States Public Health Service. The specific setting is the 26-bed nursing unit of the surgical branch of the National Heart Institute. The research interest of this branch

includes both diagnostic and treatment aspects of congenital as well as other cardiac defects in children and in adults. About 50 percent of the patients in this unit are children under 16 years of age, most of whom are there for treatment of a congenital impairment of the heart.

These children are usually in the hospital for from 1 to 4 weeks. All have been referred for diagnosis or treatment by physicians, in private practice or connected with a clinic, hospital, or health and welfare agency. Coming from all over the United States and many foreign countries, they have different cultural and religious values and a variety of economic, educational, and social backgrounds. The only common factors among them when they arrive are that *they are being hospitalized, they are away from home, and they have a suspected heart lesion with which they were born.* These common factors, however, provide a springboard from which the hospital staff can take off in trying to communicate with new patients.

From this take-off we try to see farther into the personality and experience of each patient to find meanings which can help us make the hospital experience as constructive as possible for him. What have the symptoms of his condition—this heart murmur, this shortness of breath, this easy fatigability, these frequent upper respiratory infections, this blueness, or this lack of growth and development—meant to him and his family? What was the impact on his parents of learning that their child—perhaps their only child—had heart trouble at birth? How did they find this out? From a brusque statement which held out no hope for the child's life? From a calmly made explanation providing positive sugges-

tions for future care? Or from an offhand remark ending with "you have nothing to worry about, don't pay any attention to it?"

How did they react to the diagnosis? With a frantic search for opinions of other doctors, neighbors, or well-meaning friends, resulting in further confusion, desperation, and exhaustion of economic resources? By wrapping the child in an unhealthy, overprotective blanket, sacrificing all other members of the family to satisfy his every wish or whim? Did they find any helpful resources to turn to with their anxiety, their confusion, their fears, their guilt, their anger, their frustrations, their feelings of inadequacy, or their inability to understand and accept the diagnosis?

Parents and Children

We have found that some parents have had as constructive an experience as possible in learning and facing the fact that their child had congenital heart disease. We have also found that many other parents, unfortunately, have had devastating experiences in this regard. We have seen the well-adjusted parent-child relationship. We have also seen dominating mothers, overprotective mothers and fathers, parents who are unable to deny the child anything; hostile parents who resent the hospital's rules, routines, or policies; neglecting and uninterested parents; confused and very frightened parents; and desperate parents. The difference in the parents' reactions has sometimes stemmed from the way they were handled when they were first told that *their* child had a congenital heart lesion. Therefore, we try to learn as much as we can about this from the referring source and from the parents.

We also find it important to know who these children and their parents are, where they come from, with whom and where they live. What are the parents' hopes and ambitions? How able are they to grasp the meaning of medical information? What are their other children like? What is their way of life? What does illness mean to them—stigma, weakness or inadequacy, will of God, punishment, superstition?

Very little psycho-social information about the parents or the child is made available to our staff prior to the child's admission to the hospital, and we find it impossible to "know" all of the patients and their parents during the short period of hospitalization. But it would help us greatly if doctors, nurses, welfare and health agencies, who have referred these patients to us and in many instances

know them well, understood how important such knowledge can be to those who are trying to make the patient's hospital stay a constructive rather than a devastating experience.

We often find that the parents are more upset than the child, though, unfortunately, frequently both child and parents are upset. Children, particularly those under 4 or 5 years, generally reflect their parents' reactions, whether this be anxiety, panic, calmness, or assuredness.

Every child, of course, has a distinct personality. Thus, we find it important to know *him* or *her*—his way of life, his experiences at home, in school, at play. What are his likes and dislikes, his ambitions? What has his illness meant to him, what is his understanding of what is wrong with him and of why he has to come to the hospital? Does he feel he has done something wrong for which he is being punished, or does he regard it as another way of getting attention? We are continually made more and more aware of the need to listen to the child, and to let him tell us in his own way and words what his "heart trouble" means to him.

In our nursing unit the child is in a new and, most probably, frightening situation. It is not always easy for a strange person to communicate with a child immediately. If we knew something about him prior to his coming, we would find this a substantial bridge from his home to us and could use it to facilitate communication.

Some of our children have been hospitalized before, few or many times. Some have never been hospitalized before. In either case, a child and his accompanying parent should be prepared ahead of time for what to expect at the specific facility to which the child is going. Each medical center is different from others in many ways—its location, the kind of buildings and equipment it has, and places for parents to stay, visiting hours and other rules; the kinds of services and staff available; the character of the nearby community and the cost of places to stay; the accessibility to transportation. Some of our patients arrived at the nearby Naval Medical Center or Johns Hopkins Hospital in Baltimore. One family was actually headed for New York because the parents did not know the name of the medical center to which they had been referred.

Diagnostic Procedures

Our patients for heart surgery or diagnosis are usually admitted on Sundays. The parents stay with the child throughout the admission process. They

accompany the child to the nursing unit and help with getting him settled in the two-bed room assigned to him. We try to see that he is with a compatible roommate, but unless we have some pertinent pre-admission data this effort must be based primarily on age, degree of illness, or type of care needed.

The reactions of the patients and their families to this first day of admission have been affected by the bigness and strangeness of the building; the new faces around them—admitting personnel, nurses, doctors, other new patients and their families—the anticipation of separation, and the actual separation when night comes.

We do not allow parents to stay in the hospital, and when some parents and patients come expecting to do so emotional and economic problems arise. The parents leave a frightened child (from whom they may have never been away at night) to go to a strange home, possibly by way of a strange and new transportation system, and usually at a greater cost than they had anticipated. While we have liberal and flexible visiting hours, they probably do not entirely offset the trauma to the young child of being separated from his parents at night.² The visiting hours for our unit are from 9 a.m. to 9 p.m., with permission for parents to come in early before certain procedures and surgery and to remain in the hospital overnight during the critical postsurgical period.

On the day following admission, all patients have routine X-rays, electrocardiograms, and blood tests. We try to prepare the patients and their families for these and, when indicated, we allow the parent to accompany the child during these procedures. While many children "know the ropes" generally because of former hospital experiences, each hospital has some differences in methods and procedures. If we know what the child's previous hospital experiences were we can anticipate areas of possible tension.

Other diagnostic procedures include cardiac catheterizations, angio-cardiograms, and aortograms. Not all tests are done on all children. Neither the children or their parents know this initially, but they soon observe what is going on with other patients. For some tests the children are put to sleep and for some they are not, depending on the age of the child, the nature of the test, and the reaction of the child during the study. Some tests take 2 hours, some 4 to 5 hours. All of these tests are fairly mild, but if the child and his parents are not helped to understand specifically what they can expect, they

may suffer unnecessary anxiety based on fear of the unknown, fantasy, or misunderstanding.

Since each procedure might provide a clue as to whether the child has a heart lesion, whether further studies are indicated, whether surgery or anything at all can help the child, all procedures are potential sources of tension.

Handling Tension

For many children, a simple explanation of where they are going and for what is enough to dispel the terror of the "unknown." For others, and for some parents, their apprehension is so out of proportion to the nature of the test that the services of the professional staff must be called upon to get at the root of the problem and help the child or his parent deal with it.

In our center, as at most hospitals, the medical and nursing staff see all of the patients. Therefore, they are in a position to note signs of tension, apprehension, or emotional upset. If they let the patient and his family know from the beginning that members of the staff recognize their fright, confusion, or disturbance and want to help them feel better, the parents and the patient usually can more freely express their concerns, and the days following admission become less frightening for them.

We have observed that *all* of our children and their parents come with some degree of apprehension. While some of this is dissipated after they have had a chance to have a look at the hospital, its staff, and the *modus operandi*, most parents show signs of tension throughout the period of their child's hospitalization. Some of them are able to handle this adequately on their own, some can do so with a little help from the social worker, physician, or nurse, but others need more intensive social case-work help. Their emotional reactions to the experience are dependent not only on their personality structures and earlier experiences, but also on the nature of the study procedures to be undergone, the implications of the final diagnosis, the recommendations made, and the physical reactions to whatever surgery takes place.

In general, the children who are accompanied by parents seem less tense than their parents. Perhaps we do not know them as well as we know the parents, or perhaps they are less aware of the implications of what they are undergoing. The few children who have come without their parents have exhibited signs of extreme fear, tension, or anxiety.

Periods of waiting may be periods of heightened

anxiety for the child and his parents alike. Both child and parents may dread the tests—a state of mind which may be prolonged for the parents while they wait for the child to return to his room. Waiting to hear the results of tests may also increase anxiety. This is more apt to be true of parents than children, though we have also seen children whose anxiety during this period reached a point near panic or immobilization. Hospital staff busy preparing other patients for tests, surgery, or return home may fail to notice the extreme anxiety being suffered by some children and parents while they are waiting to hear the recommendations.

Reactions to Recommendations

The most critical period emotionally for child and parents comes when they hear the surgeon's recommendations. These will take one of four directions:

1. No surgery is recommended because the suspected lesion either does not exist or is insignificant.

When this news is forthcoming, the anxious moment is usually replaced immediately by a sense of relief. In some instances, however, the reaction felt may be anger because of the child's past subjection to unnecessary tests and hospitalizations and to unnecessary limitations on normal childhood activities; because of the parents' emotional need to have a sick or dependent child; or because of the child's need to continue to receive the attention he has enjoyed.

2. Surgery offering low risk and a high chance of cure.

Parents' reaction to this is usually one of relief and confidence in the surgeon's decision and skill. However, some parents are unable to express real questions about this decision when the child is asymptomatic and the risks involved in surgery even if described as minimal.

3. Surgery with significant risk for the child who has increasing and seriously disturbing symptoms.

A realistic response to this is fear for the life of the child. But parents differ greatly in their ability to understand the implications of this recommendation and the gravity of the choice they must make.

4. No surgery is available for the specific lesion or lesions in the child's heart.

A realistic response to this is loss of hope that the child will live to grow up. Crucial factors in the ability of the parents and child to face the inevi-

table are the way they have been informed of it and their abilities, emotional and intellectual, to understand the diagnosis and recommendations for care. The whole professional staff of the unit is responsible for seeing that the parents and the child get the help they need in asking questions, in expressing their feelings, in understanding the diagnosis, and in following recommendations for treatment.

There is enough of a realistic basis for fear when parents and child are confronted with approaching cardiac surgery or the grim prospects that an untreatable cardiac lesion presents without their having to contend with unrealistic ideas, concerns, or fantasies. Physician, nurse, medical social worker, chaplain, and a psychiatrist if indicated must all be available to patients and their families who are faced with these grave findings. No one professional discipline can provide adequate help alone.

The Surgical Period

At our hospital some children for whom heart surgery is recommended are discharged to return for the operation at a later date; some remain to be operated upon within the next week or two. When the time approaches, the focus of all staff is on preparing the child for the operation. The surgeon, the nurse, the physical therapist, the anesthesiologist, the social worker, the chaplain are all involved. The other patients and their families also have an effect—sometimes good and sometimes bad—on the child's emotional condition during this presurgical period.

How far in advance the child is told the date of surgery depends on his age and emotional makeup. Although giving this information a long time ahead of the date sometimes seems to increase and prolong anxiety unnecessarily, it allows more time for helping the child to bring out his questions or express his fears. When both child and mother are extremely anxious, time is needed to help them both. If the staff is aware of the emotional condition of the child and his parents early in the hospital stay there is a better chance of preparing them psychologically for the more tense surgical period.

Children under 4 usually depend on their parents to take care of any situation, so if either the child's mother or father is with him throughout his hospital stay, when he is told about the date of the operation is not very important. What is important is the way his parents and the staff tell him about it and about what will happen then. If the child's parents are

not with him, the anticipation of surgery and the postsurgical period become much more frightening and the potentials for emotional and even physical trauma are greater.

For many of the operable patients and their parents the day of surgery and the 3 or 4 days afterward are, understandably, their most anxious days. The patient leaves the unit early in the morning and does not return until 2 to 6 hours later, depending on the type of operation. The parents remain in a solarium near the nursing unit while the operation takes place on another floor. The staff makes every effort to prepare the parents for the length of this waiting period, and for the fact that they cannot hear from the surgeon until this period is nearly over. The social worker is available to give the parents emotional support and has told the surgeons and nurses of any previous impressions she may have gained about their possible reactions to the strain. A chapel and Catholic, Jewish, and Protestant chaplains are also available to the parents.

After the patient returns to the unit the parents are allowed to see him in the postoperative room. They have been prepared to see the oxygen tent, the chest tubes, the attachments for intravenous infusions, and the like. For most parents the knowledge that the operation is over and that their child is back in the unit is a tremendous relief, although they have been told of the critical aspects of the immediate postsurgical period. Some parents are still overwhelmed by emotions at the first postoperative sight of their child.

For the child, the time in the postoperative room—usually about 3 days—where there are usually one to three other postsurgical patients is the most frightening period of all. He cannot understand his pain, his reactions from the anesthesia, the chest tubes, the need to cough. He shows his fright by his actions and in the expression in his eyes. During this time the child has a special nurse. Many children are unable to verbalize their fears and some of these patients physically cannot do so because of the nature of their operations, so adults, and especially the nurse, must try to understand the nature of their fears and to help them. They can explain the purpose of the frightening procedures and let the child know that these are the same for everyone, show him that Mommy and Daddy are at hand, agree that the pain hurts, tell him over and over—if reassurance is justified—that he is going to be all right. They can also try to keep his fright from becoming aggravated by what is happening to other people in

the room. The patient does not know what is going to happen to him, and if another patient gets into trouble, undergoes other unpleasant procedures, or has to go back to the operating room, he has no way of knowing that these things are not in store for him. False reassurance, however, can be harmful, and only honest reassurance should be given.

We have known three children who in this postoperative period developed symptoms of gastric ulcer, which is closely associated with stress. All of them had previously shown signs of considerable tension but before the operation had been unable to express their fear. Careful evaluation of the degree and cause of the patient's tension and anxiety ought always to be made before surgery, and if this is extreme, surgery should be delayed if possible.

Children and parents alike tend to relax when the child leaves the postoperative room. Parents can give much more *verbal* expression to this feeling of relief than the children.

Most children are able to leave the hospital about 10 days or 2 weeks after their operation. Observations of the "cured" children on their followup visits indicate that the majority adjust well to having a normal heart, and little continued "cardiac neurosis" occurs.

If the surgery has been only a first step, the child and his parents are faced with the prospect of returning for more surgery at a later date when the child is older and larger. If we have been able to keep the emotional trauma of the first experience to a minimum, there is more hope that the patient and family will suffer less anxiety during the next operation.

If the surgery has not helped, that is, if the lesion is found on the operating table to be uncorrectable at that time or at all, the parents and child are faced with the loss of hope, or with the need to return for further and more serious surgery. This can mean renewed anxiety and apprehension, possible economic strain, renewed family separation and, sometimes, exhaustion of resources.

Causes of Tension

The greatest support for a child during any part of the experience of hospitalization is that his parent or parents be with him.

In our unit one of the social worker's first responsibilities is to try to make it possible for at least one of the parents to bring the child to the hospital and to remain with him whenever hospital rules permit. Sometimes this has not been possible and

we have had children arrive at the hospital and remain without any visits from members of their family during the entire period. One was a foster child with no parents who cared. Some have come from places so distant—Alaska, even Iran—that the cost and time involved in travel have been too much for the parents. A few have been from families in which the mother had other children to care for while the father was away at work. In some instances community resources—union welfare funds, public welfare departments, crippled children's services—have helped the parents to get to the hospital for at least the critical pre- and post-surgical periods. When no parent arrives the unit tries to provide from its own staff a parent-like person to give the child special attention.

To the child, parents—even those who are not able to give their child a sufficient measure of love—mean safety and security, particularly during a stressful period. In our hospital we would much rather have a very anxious and disturbing parent turn up with a child than to have the child arrive alone. We would rather have both parents than one alone, as they can be a source of strength to each other.

We believe that much—though certainly not all—of the anxiety that children and their parents bring with them to the hospital might have been prevented:

1. If the person who had previously dealt with the family in relation to the child's illness had known more about the child's and the parents' background and their experience with illness and other crises, their intellectual and emotional makeup, their ability or inability to understand the meaning of the diagnosis, and other family problems—such as unemployment, social isolation, or marital discord—which might be aggravated by or projected onto the child's illness, and had shared this knowledge with the medical center staff.

2. If the person who had informed the family or child of the suspected heart condition had taken pains to dispel confusion and to avoid arousing unnecessary fright or over-optimism.

3. If the home community had had available the skills and facilities for the earlier treatment of certain defects and for helping the family to meet the cost of study and care, to understand what to expect in relation to the illness, to reach decisions about

taking the child to the medical center, to make arrangements about getting there with due regard for other members of the family, and to deal with peripheral but aggravating and pressing family problems.

4. If the child had received some help in understanding his illness, and in clearing up his own fantasies, fears, and expectations about it, such as regarding it as a punishment for some undefined transgression, being in constant fear of dropping dead, or expecting constant attention.

5. If the child (or his parents) had not already had an unhappy hospital experience.

6. If the child's fears of a complete unknown (and those of his parents) had been allayed by careful briefing on what to expect at the medical center.

The community, of necessity, bears the brunt of responsibility for the provision of services to help solve the various kinds of problems worrying the family and the child. The hospital, even though separated by considerable distance from the home community, has equal responsibility for maintaining a constructive continuity of communication in relation to the patient's care and for letting the responsible persons in the community know about the kinds of problems these patients and their families are apt to face and the preparation they will need for the hospital experience. And while the child is hospitalized the hospital must, through the combined efforts of its medical, surgical, nursing, and social service, do everything possible to see that day to day experiences do not arouse unnecessary anxieties in the patient or his parents, and that help is forthcoming for dealing with those anxieties that are unavoidable.

These are not insurmountable problems, and we may feel more hopeful in trying to solve them if we compare the promises of cardiac surgery today with those in 1883 when a surgeon named Billroth said, "Let no man who hopes to retain the respect of his medical brethren dare to operate on the human heart."³

¹ Lesser, Arthur J.: The children's titles in the Social Security Act. IV. Health services—accomplishments and outlook. *Children*, July-August 1960.

² Robertson, James: Young children in hospitals. Basic Books, New York, 1958.

³ Bland, Edward F.: Surgery for mitral stenosis; a review of progress. *Circulation*, February 1952.

*A course in family medicine in a
medical school provides for . . .*

SOCIAL WORK PARTICIPATION IN MEDICAL TRAINING

LONIS LIVERMAN
Assistant Professor

NATHALIE KENNEDY
Lecturer in Medical Social Welfare

*Department of Preventive Medicine and Public Health, School of Medicine,
University of California at Los Angeles**

SOcial WORK participation in medical education, although not a recent innovation, has gained considerable momentum in the past 15 years. During this period medical education has undergone extensive reevaluation by the medical profession.

This reevaluation, in which prominent social work leaders have been asked to participate, has led to the recommendations, among others, that medical knowledge should include knowledge of the social and emotional forces which affect patient care^{1,2} and that this should be recognized in medical school curricula through "the use of the medical social service staff on a faculty basis, as a specialized department capable of supplying instruction in the principles and practices of applied sociology."³

As changes in the curricula of several medical schools have taken place and as new schools have been established, the number of social workers added to medical school faculties has increased.

In 1946 the California Legislature appropriated funds for the construction of a new medical school at the University of California at Los Angeles. In

planning the curriculum it was possible to incorporate some of the findings of the reevaluation studies of medical education and to include content regarding the social and emotional forces which affect medical care. Therefore, a family medicine course was designed. From the inception of the course in 1951, when the first class of medical students was admitted, social work instructors have been associated with it.

The family medicine course has been described as a "course in the problems of communication and human relations"^{4,5} as these are related to the practice of medicine. It is designed to complement the general medical curriculum and has three functions:

1. To bring to the attention of students the importance of sociological factors in the care of patients through observation and study of the structure of the family and the various forces reacting within and upon it.
2. To help students deepen their understanding of the meaning of human development in our society as it relates to medical care. (The term development, as used here, encompasses physical, neurological, mental, personality, and social development.)
3. To provide first and second year medical students with an opportunity to deal directly with patients, sustaining their interest in patient care until they have daily patient contact in the third and fourth years of medical school.

Some changes have been made in the details of the course since its beginning in 1951, but basically it remains the same.^{4,5} The general procedure is as follows: Early in his first year in medical school

*The authors acknowledge the cooperation of Drs. Arthur H. Parmelee, Jr., associate professor of pediatrics, and Justin D. Call, assistant professor of psychiatry, School of Medicine, University of California at Los Angeles.

each student is assigned a family in a special teaching well-baby clinic in a city or county district health office. The student follows this family throughout his 4 years in medical school by periodic visits to the clinic and by home visits. In the first year the student comes for these clinic appointments once a month and makes a minimum of three home visits during the year. Once a month the entire class convenes for a case conference on interesting and medically important family situations or child development problems.

In the second year the student has three well-baby clinic appointments with his assigned family, scheduled at 3-month intervals. These follow the same general pattern as the first-year appointments. He also makes at least two home visits. In addition, he visits the University Nursery and Elementary School once a month during the first semester. He observes preschool and school age children in the classroom and on the playground and studies the nursery school program and the elementary school curriculum from the standpoint of child growth and development. These observations provide a continuum in the student's learning about child development from infancy in the well-baby clinic through childhood in the school. They also give medical students an opportunity to consider the impact of the elementary school on the development of the individual and the value of this knowledge to the physician in practice. Each month, preparatory to the observations, the entire class attends a lecture, followed by a discussion.

In the second semester of the second year, the family medicine course and the course on introduction to clinical medicine are integrated and each student is assigned another family to follow in addition to the family assigned him the first year. This second family is selected from patients registered in one of the clinics of the university medical center. The student is introduced to the patient in connection with his studies in physical diagnosis at which time he takes a complete medical and social history and does a thorough physical examination. He makes a home visit to amplify his information about the patient's total social situation and sees the patient again in the clinic as indicated.

In the third year the student sees his first-year family once in the well-baby clinic and is encouraged to follow the family through home visits and telephone calls. No clinic visits are scheduled in the fourth year but many students continue to maintain contact with the families.

An attempt is made in the third and fourth years to help students extend the concepts developed in the first 2 years to the daily care of their patients in the clinics and on the wards. In the third year, while students are assigned to pediatrics, they meet once a week with the pediatric and social work instructors in the course and the social worker in the pediatric clinic to discuss the social aspects of patient care both in a general way and in relation to the specific patients they are seeing. A similar program continues in the fourth year. In addition, all of the social workers of the university hospital are involved in the family medicine course. They work closely with students on the problems of any of the patients assigned to the students in the course that may be under care in the university medical center, and they are also available for consultation regarding other patients.

Social Work Participation

Present at each teaching well-baby clinic session in the program for first-year students are the clinician (a pediatrician), the social worker, and the public health nurse, as well as the students. The clinicians and the social workers in these special clinics are members of the medical school faculty. The public health nurses are provided by the city and county health departments. Families for student assignment are selected by the public health nurses from the clientele of the regular well-baby clinics. Criteria for selection include: the presence of an infant under 6 months of age; intent on the part of the family to remain in the community for at least 4 years; and willingness on the part of the family to participate in the program. Families with overwhelming medical or social pathology are excluded.

No more than six or seven students and families are scheduled for each clinic session. All of the students attending on a given afternoon are present when the clinician examines each baby and interviews the mother or both parents. Before each family and child are seen, their student presents the social history information he has secured about them to the clinic staff and to the other students. The clinician makes use of this information in his discussion with the family, pursuing some of the mother's questions in greater detail and adjusting his comments and recommendations to her social and cultural needs. Thus, the students can see that the histories they have obtained are significant and functional in the rendering of care in the well-baby clinic.

Following the clinic appointments, the students have an opportunity to discuss what they have observed with the staff. These postclinic discussions consider parent-child relationships, sibling relationships, implications of pathology or abnormality noted during the physical examination of the child, eating and sleeping patterns of children, toilet training, discipline, and other matters related to the normal growth and development of children. They also deal with the influence of the parents' own families and cultural backgrounds on child rearing practices, on attitudes toward health and medical care, and on the relationship of the families to the community, including social, school, and religious ties.

At the monthly case conferences, except at the first two sessions which are devoted to lectures, the students make the case presentations and discuss them with help from the instructors and occasional invited guests. The cases are selected to illustrate general concepts that emphasize the major objectives of the course. The first-year students' presentations during a recent academic year included: *December*, communication with a talkative mother and with a quiet mother, presented by two students; *January*, cultural adaptations of a Mexican-American family; *February*, a family with an adopted child, discussed after presentation by a professor of law; *March*, a mother with diabetes and healed tuberculosis; *April*, a mother with a psychiatric problem and hypertension, discussed after presentation by a professor of psychiatry; *May*, a family with a large hospital bill and other medical expenses, discussed after presentation by a hospital administrator. The three monthly sessions which preceded these presentations were devoted to an orientation lecture, a lecture by a sociologist on the family in our society, and a presentation by a fourth-year student of his experience with the family assigned to him in his first year.

Each student is required to submit a report of his observations of his family at the end of the first semester and a supplementary report at the end of the year. By the end of the first year, students are expected to have learned some of the pertinent social history of the family in each of the following categories:

1. Family constellation: name, age, and sex of each member of immediate family and other members of the household; how long married; and length of time in the community.
2. Family cultural background: race, nationality, ethnic and cultural traditions, religion, parental family backgrounds, and educational level of family members.
3. Family characteristics: housing, neighborhood, employ-

ment of family members, family mobility, and health of family members.

4. Current family social situation: intellectual interests, hobbies, and other activities; family unity or diversity of interests, and family attitudes toward health and medical care.

5. Family relationship with the community: school attendance, church affiliation, club and civic activities.

Social Work Teaching

The goal of social work teaching in the family medicine course is essentially the same as in other social work participation in medical education—to transmit some of the broad principles and concepts of professional social work knowledge that can be useful to physicians in the practice of medicine. These include: acceptance of the individual's right to self-determination within the limits imposed by the situation in which he finds himself and the limits set by society; respect for the dignity of the person; understanding of the need for a family-oriented approach to medical and psychiatric problems and for a careful social exploration of each case; and awareness of the impact of the medical problem on the patient and the family and of the need to identify the strengths in a situation that can be enlisted in the patient's behalf.

Because these concepts and principles are not the exclusive province of social work, responsibility for transmitting them is shared with other professional disciplines on the medical school faculty. The social work teacher, however, also helps the medical student to attain knowledge of the function of social work and to develop skill in using social work services effectively for his patients.

In the first-year program of the family medicine course social work teaching goals are appropriately limited. Since this course is planned to involve all 4 years in medical school, the full goal is not expected to be achieved in any one year. The objective in the first year is to help the student enhance his understanding of the family assigned him and to develop skill in communicating with its members. During this year, the social work instructor tries to help the student to sharpen his awareness of the stresses affecting his assigned family and its relationship to the community and to become more cognizant of the significance of its environment and cultural background, which may be different from his own.

In working toward attainment of these first-year goals the social work instructor functions in the well-baby clinics as an observer of students and families and of the interaction between them, as a specialist

with responsibility for teaching specific content, and as an aid in promoting group rapport. In addition, she carries on interviews with students to help them extend and consolidate the knowledge gained in the clinics and participates with other staff members of the course in the on-going evaluation of students' progress.

What the social work instructor observes is determined by the kaleidoscopic character of the clinic sessions. While the clinician is simultaneously examining an infant, counseling the mother or both parents, and teaching the students, the social work instructor is in a strategic position to observe the dynamics of personal reactions and relationships. Depending upon the situation, these observations encompass the students' comfort or discomfort in his student-observer role; the reactions of the students to the examination of the infant; the parent-child relationship; the clinician's counseling and the mother's response to it; and the students' comprehension of the clinician's instruction.

On the basis of these observations, the social work instructor advises the students at appropriate points during the clinic sessions about certain areas on which to focus attention. For instance, a mother who usually communicates poorly may, in response to the skillful interviewing of the clinician, be furnishing significant information about her baby. At this stage in the students' learning, the clinician's interviewing techniques may be too subtle for the students to grasp unless specifically pointed out to them. While this is being done, the instructor can stress the importance for present and future care of the information the clinician is seeking. If more amplification is indicated, the social work instructor brings the incident to the clinician's attention in the informal discussion period.

At other times the students may ask the social work instructor about the validity of some observation they have made regarding a single family or a group of families seen during the afternoon. For example, after observing a young mother with her first-born child, they may want to know whether she seems unusually anxious or whether all young, inexperienced mothers act as though they are afraid of handling their babies.

The students are encouraged to describe what they have observed about the mother and child which created the impression they received. With the social history available, the social work instructor points out some of the reasons why the young mother may seem unduly apprehensive and suggests various

possibilities for student observation in future sessions. Later, when it is timely, the social worker can refer back to the experience and others like it to enhance the students' understanding of behavior and its wide range of differences. If a mother has made good use of the anticipatory guidance and support she has received in the clinic, this important development can also be pointed out to the students.

The social work instructor also tries to empathize with the mother during the clinic visit in order to explain the mother's feelings and behavior, and the possible reasons for them, to the students in the post-clinic discussions. At the same time she tries to be sensitive to the impact of any particular situation on the students in order to help them bring out their questions and feelings in the postclinic discussions or later in an individual conference.

Another function performed by the social work instructor in the well-baby clinic is to help create a situation conducive to learning—a relaxed climate in which the students' curiosity can be stimulated and in which they feel secure in seeking help. While the students find this early-patient contact stimulating, the student-observer role is a strange and anxiety-producing experience for most of them.

In the general orientation at the beginning of the semester, students are provided with written material about course expectations which includes a description of their role in the clinic sessions. However, most of them have had no experience in observational situations and, understandably, they have difficulty in grasping all the implications. Also, the very nature of the clinic sessions poses problems for them. Unless they are helped to feel somewhat at ease early in the course, they have difficulty in using the learning experiences offered to the best advantage.

The parents also tend to feel uncomfortable in this unaccustomed situation of being observed even though the public health nurse told them what to expect when she asked them if they would participate. The whole staff makes an effort to help the mothers feel at ease in talking with the clinician in the presence of the group. The social work and medical instructors and the public health nursing staff work together to promote an informal, friendly atmosphere.

Individual Interviews

Students who are having difficulty or request help with their assigned families have individual interviews with the social work instructor. These conferences are designed to help the student deepen his

understanding of his family and gain some awareness of his own attitudes and how they affect his relationship with the family. The social work instructor is expected to serve as an objective, nonthreatening person to whom the student can reveal his thinking and concerns about his assigned family and any problems he may have in his contacts with them.

For example, one student requested an appointment to discuss a family because, during one of his home visits, the mother had expressed concern about the problem behavior of her 5-year-old boy. Some clues to this problem had been revealed in the clinic sessions but the mother's feelings had been respected when she was unable to discuss the situation there. In the home the student noted the child's aggressive behavior and the mother's inability to cope with it. He said he felt that the parent-child relationship was disturbed but, even though the mother seemed to be asking for help, he doubted that she or the father were yet ready to accept referral to an appropriate agency. Instead, the student had offered to consult with the social work and medical instructors, a suggestion accepted by the mother.

In taking the problem to the social work instructor, the student was testing his observations, seeking more understanding of the family, and asking for guidance on his role. The social work instructor, from her impressions of the mother at the clinic and the additional information furnished by the student, could support much of the student's evaluation. She pointed out to the student the facilitating role he had played by listening to and empathizing with the mother. He was encouraged to maintain his role while the social work and medical instructors took a more active part in helping the mother to work through her resistance to a referral for appropriate help.

Interviews are also scheduled with students who have been selected to present information about their assigned families for discussion at the monthly case conference. It is the rare student who is not apprehensive about his ability to perform before his classmates and instructors. In the interview the social work instructor assesses the degree of the student's anxiety. If this does not seem too great for him to handle, she asks him to describe his assigned family to the class, focusing on a particular aspect of the family situation that emphasizes the concept chosen for discussion in that month's conference. She also helps the student select and organize the material, clarify areas about which he has

questions, and resolve any of his own feelings about the family which might impair his ability to make the conference a constructive learning experience for himself and for the class.

Because it is not unusual for students to feel uneasy and guilty about revealing information they have secured about the family to the entire class, the social work instructor tries to help the student chosen to present a case to understand and accept the need for developing skill in the critical evaluation of social as well as medical data. She tries to help him to see that objective evaluation of social history information need not imply punitive or unfavorable criticism of a family. She guides the student in selecting the material to be presented so that he will feel secure in what he is saying about the family, and will be able to recognize the significance and appropriateness of the material to his own and his classmates' learning.

Evaluation

The evaluation of each student's progress is a continuous process interwoven with the functions just described and beginning with the staff's first meeting with the students. Initially, in order to become better acquainted with the students and to establish some baseline of their knowledge in relation to this course, the staff secures information about their educational background and experience. Since most of the students are strangers to each other at the beginning of the semester, this is done in the small group at the clinic, to give the students an opportunity to know more about one another. Even at this early stage some of the more expansive students sometimes reveal attitudes and interests which may have a significant bearing on their probable progress or lack of it in the course or which may alert the faculty to certain learning needs.

Some immediate impressions of the individual students at the first clinic session are gained by the manner in which they conduct themselves; by the way they relate to the instructors, the clinic staff, and the other students in the group; and by their response to their assigned families. The medical and social work instructors and the public health nurses pool these cursory impressions, recognizing that they will be modified and revised later as more knowledge of the students is gained from clinic contact and observation as well as from individual interviews. This information is important in helping students

who have trouble establishing rapport with their families or who are blocked in their learning.

The students' medical school application and subsequent progress reports are available to the social work instructor for review. She keeps a detailed chronological record on each student which includes the data from the application records, her impressions of the students from her observations in clinic sessions, and information gathered through informal discussions, student interviews, and class presentations.

The written reports which the students submit at the end of each semester are reviewed by the medical and social work instructors and the public health nurses assigned to the course. In these reviews they use an evaluation scale developed for this purpose. In addition, the medical and social work instructors prepare written comments on the reports, which are discussed with the students and given them for future use as they follow up their families. Each instructor also gives a general overall evaluation of the report in terms of this particular orientation and makes suggestions as to specific areas needing further exploration. These student reports, along with the chronological records kept by the social work instructors, are used to assess the degree to which the student has been able to assimilate and use the material presented and discussed in the special well-baby clinics, and the extent to which the

goals of the family medicine course are being reached.

The two social work instructors who participate in the first year program of the family medicine course function in essentially the same manner, even though they serve in different well-baby clinics with different medical instructors and have been free to create their roles in their own particular ways. The medical faculty has given them support but has not prescribed the methods and content of their work nor in any specific way charted its development. The fact that no marked differences have developed in the way these two social workers operate nor in the content of their work suggests that the medical and social work faculty are in agreement about the essential social work knowledge appropriate for teaching in this kind of medical educational program and about the most effective methods for transmitting it.

¹ The Commonwealth Fund, New York: Widening horizons in medical education; a study of the teaching of social and environmental factors in medicine. (A report of the joint committee of the American Association of Medical Colleges and the American Association of Medical Social Workers.) 1948.

² Allen, Raymond B.: Medical education and the changing order. The Commonwealth Fund, New York, 1946.

³ Youmans, John B.: New approaches to education for the practice of medicine in modern medicine. *Medical Social Work*, October 1954.

⁴ Parmelee, Arthur H., Jr.; Liverman, Lonis: The elementary school in medical education. *Journal of Medical Education*, September 1958.

⁵ Parmelee, Arthur H., Jr.; Swengel, Ethel; Adams, John M.: The family in medical education. *Pediatrics*, October 1954.

As the individual attributes of the child are observed and interpreted by both parent and physician, a balance between objectivity and subjectivity can be achieved. . . . Parents soon learn that certain types of responses or behavior may be average in this child, whereas in another child in another environment, such a deviation may be an expression of pathology. The infant respected for his individuality may find that this kind of environment requires him to respect others about him for their individuality. . . . The cultivation of an appropriate balance of objectivity to subjectivity in regard to others appears to be a process upon which emotional growth can evolve.

This problem of interpersonal relationship appears to be one of our largest problems for the future. . . . We cannot rigidly impose traditional values, subjectively evolved beliefs and faiths, or political ideology upon others. The real values within each of these must be appropriately defined in the light of the individuality of the person or the social group we wish to aid.

John A. Anderson, M.D., Professor of Pediatrics, University of Minnesota Medical School, to the 1960 White House Conference on Children and Youth.

BOOK NOTES

THE HEALTHY CHILD; his physical, psychological, and social development. Harold C. Stuart and Dane G. Prugh, editors. Foreword by Martha M. Eliot. Harvard University Press, Cambridge, Mass. 1960. 507 pp. \$10.

Children's health status in relation to their maturity and growth is considered from many points of view in this textbook for persons in various professions serving children. Its chapters have been contributed by representatives of a number of disciplines—pediatrics, education, nutrition, social work, psychiatry, psychology, preventive medicine, and neurology. They are presented in general subject groupings, such as principles of growth and development; fetal development and childbirth; nutrition; physical, psychosocial, personality, social, and intellectual development; and community health services to promote healthy development. All the discussions emphasize the relation of physical and psychological aspects of child development to family life and other social conditions.

The text consists of an extension and rearrangement of the materials used in large part by the authors in a series of institutes on child growth and development offered by the Harvard School of Public Health to workers in State public health programs.

PARENT GUIDANCE IN THE NURSERY SCHOOL. Margarete Ruben in collaboration with others. Foreword by Anna Freud. International Universities Press, New York. 1960. 72 pp. \$2.

This book offers help for nursery school directors and teachers in guiding parents who are disturbed by their children's behavior. A sample or "model" discussion with each of a number of mothers is reported, each on a specified problem, such as thumbsucking, feeding, toilet training, timidity, sleep, and jealousy. Each discussion is

based on psychoanalytic educational principles.

While illustrating techniques for parent counseling, the author notes some of their limitations and describes such counseling as an art that is perfected through "experience in human relations and everyday living, supported by an ever-increasing body of knowledge along psychological, educational, and cultural lines."

UNDERSTANDING JUVENILE DELINQUENCY. Lee R. Steiner. Chilton Co., Philadelphia. 1960. 199 pp. \$3.95.

In this book the author presents a collection of case stories, based on her experience as a psychiatric social worker, of boys and girls brought before courts for various offenses, including larceny, drug addiction, prostitution, and homicide.

The psychoanalytic approach to treating such children, the author maintains, can succeed only with middle-class boys and girls who are verbally oriented, and not with the action-oriented youngsters of the lower income group—those who chiefly are brought to court. She adds that the fact that most therapists are at least middle class is a handicap in work with delinquents. She opposes laying the blame for a child's actions on the parents, especially as that is likely to make child-parent relations even worse than they were before.

FUNDAMENTALS OF CHILD PSYCHIATRY. Stuart M. Finch. W. W. Norton Co., New York. 1960. 334 pp. \$5.95

This textbook's 15 chapters discuss such subjects as psychoneuroses, behavior disturbances, and chronic emotional states in relation to physiologic changes in children; the psychotic child; the handicapped child; history taking and examination; and parental psychopathology.

The author reminds readers that child psychiatry, though a subspecialty

of general psychiatry, is not merely adult psychiatry applied to children, and that certification in child psychiatry requires a year more of training than is required for certification in general psychiatry. The book is addressed to students in medicine—especially pediatrics—nursing, psychology, social work, and related fields.

The author is associate professor of psychiatry and director of the Children's Psychiatric Hospital, University of Michigan School of Medicine.

GROWING UP IN NEWCASTLE UPON TYNE; a continuing study of health and illness in young children within their families. F. J. W. Miller, S. D. M. Court, W. S. Walton, E. G. Knox. Published for the Nuffield Foundation by the Oxford University Press, New York. 1960. 369 pp. \$5.75

Addressed chiefly to doctors in family practice, in preventive medicine, or in hospitals, who care for children in different ways, this book reports a study of the illnesses in the first 5 years of life of more than 800 children in an English town, in relation to the quality of the care they received from their mothers and to other family circumstances. In the 5 years between 1947, when all the children were born, and 1952, an average of 10 illnesses per child were recorded; minor illnesses were ignored.

The most obvious and most important feature of unsatisfactory family environment noted in relation to the children's illnesses was a low standard of maternal care.

A typical finding was that the incidence of bronchitis and pneumonia was 10 times higher in the families of laborers and other unskilled workers than in professional families. In that connection the authors note that in infancy at least, social factors largely determine whether a given infection will develop as a cold, bronchitis, or pneumonia.

Summarizing their 5-year impressions of the children's human environment in relation to their illnesses, the authors maintain that now, in view of the controllability of serious infection, the reduction of primary poverty, and the improvement of standards of hygiene, nutrition, and education, the major need for child health is improved standards of family behavior.

HERE AND THERE

International Conference on the Family

The first international conference on the family ever convened in the United States took place in New York, August 23-26, 1960. This was a joint project of the International Union of Family Organizations and the National Council on Family Relations. The meetings were held at Teachers College, Columbia University, with a registered attendance of 1,717, including 127 delegates from 31 foreign countries, many of them officially representing their Governments. Representatives from United Nations agencies, including UNICEF, were also present.

The conference theme was "Personal Maturity and Family Security." In the keynote speech at the opening session Katherine B. Oettinger, Chief of the Children's Bureau, defined "personal maturity" as the ability to "recognize and accept our deep responsibility to work toward the day when a life of freedom and security will be possible for every child in every nation of the world." In the closing address David R. Mace, president-elect of the National Council on Family Relations, dealt with some of the specific problems involved in the quest for international understanding, drawing especially from his experiences in the U.S.S.R. this past summer.

In each plenary session, each section meeting, and each discussion group the conviction was expressed that in the days to come there can be no such thing as security for families anywhere unless the basic needs of families everywhere are met through worldwide cooperation.

As the discussions developed, it became apparent that European and United States delegates approached the question of family security differently. In Europe programs of research and service have concentrated on economic security for the family; in the United States the focus has been on family stability in the psychological sense; and these differences in approach were evident throughout the conference, both in the formal program and in informal discussions among the conferees.

In a paper on economic aspects of family security, Pierre de Bie, president of the Belgian Conseil Supérieur de la Famille, said: "Seeing that an international congress is a kind of crossroads, a place where viewpoints come face to face, and ideas are exchanged, I should like to propose an exchange to you now. It is this: that the Americans in the audience leave this meeting more conscious of the measures and institutional mechanisms by which the economic stability and the financial security of families can be reinforced; and that we Europeans return home more sensitive to the need for research into and knowledge of the conditions governing the equilibrium and psychological adaptation of the members of the family."

In summarizing the conference Dr. Evelyn Duvall stressed the following points of general agreement: That family patterns are changing all over the world; that family security includes but is more than economic security; that both "security" and "maturity" are terms which will be more meaningful when they have been more carefully defined. Three major problems of concern to the conference were, according to Dr. Duvall, too early marriages, child rearing dilemmas, and confusions in value systems.

From the discussion groups came such thought-provoking questions as: Isn't insecurity conducive to creativity? Is the equalitarian family really our goal or is flexibility in family roles a more mature concept? Is it not possible that television used internationally could be one of the best means we have for bringing children of the world together? How do we unlearn judgmental attitudes?

The conferees expressed a strong belief in education for family living, especially parent education, and in professional counseling — premarital, marital, and general family counseling. Many of them also went firmly on record for deeper and more penetrating studies of family life, several members pointing out that the very diversity of research findings could lead to the formulation of more meaningful basic concepts.

It seemed to be generally assumed

throughout the conference that education based on the findings of research can help man learn how to live with others, beginning with his family. There was, also, considerable emphasis on the need for clarifying values in the non-Communist world so that these may become a more powerful dynamic in the working out of relations with Communist countries.

Abstracts of all reports of research were available at the conference in mimeograph form as were some of the full papers. Information about the availability of this material may be obtained from the executive secretary of the National Council on Family Relations, Ruth H. Jewson, 1219 University Avenue, SE, Minneapolis 14, Minn. The next international conference on the family will be held in Madrid in 1961.

—Muriel W. Brown

International Congress on Nutrition

Mothers and children were in the forefront of the discussion during many of the sessions of the Fifth International Congress on Nutrition, which took place in Washington, D.C. September 1-7. Childhood undernutrition and malnutrition are major causes of morbidity and mortality in many of the 60-odd countries that were represented by the more than 2,000 delegates to the first of these Congresses to be held in the Western Hemisphere.

Maternal and child nutrition was the focus of a number of summary reports of original research in several scientific sessions as well as of a half-day panel presentation by representatives of seven countries in five continents. Scientific and panel sessions alike gave opportunity for members of the audience or fellow panelists to question the speakers. The nutritional needs of mothers and children were dealt with also in several of the scientific and technical exhibits.

Although differences of opinion on a number of subjects emerged in the panel discussion on maternal and child feeding, there was unanimity on the superiority of human milk for infants. Dr. C. Gopalan of India expressed concern over "an inverse relationship between the position of the mother in the socio-economic scale and her lactation." On the basis of observations in widely

separated tropical countries, Dr. D. B. Jelliffe expressed the opinion that it was probably impossible to reverse the trend to artificial feeding in areas that are already industrialized, but that there might be some hope in averting the abandonment of breast feeding in still underdeveloped areas by application of anthropological knowledge about cultural factors.

Protein requirements of infants and young children received considerable attention. Papers from several countries reported progress in the development of a protein supplement of high nutritive value from mixtures of indigenous plant products. Some optimism was expressed as to the prospects for overcoming the technical difficulties in the way of developing fish flour on a commercial scale for use as a protein supplement in certain countries. Supplementation of a predominantly cereal diet by synthetic amino acids was another possibility suggested.

Throughout the Congress, delegates were reminded that improvements in the quantity and quality of the world's food supply can confer the maximum benefits only on a population that does not exceed the productive capacity of the planet.

The proceedings of the Congress, including the final papers, are scheduled for publication as a supplement to the December 1960 issue of *Federation Proceedings*. The Sixth Congress is to be held in Edinburgh in 1963.

—Marjorie M. Heseltine

Conference on Juvenile Delinquency

Juvenile delinquency, prevention of crime resulting from economic and social changes in less developed countries, short term imprisonment, treatment of prisoners before and after release, and the integration of prison labor in a national economy were subjects discussed at the Second United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in London August 8-20, 1960. The Congress was attended by representatives of governments, specialized agencies, intergovernmental and nongovernmental organizations, and individual participants professionally interested in the subjects to be discussed, such as criminologists, prison officials, law enforcement officers, and social workers. Attendance came

to 1,000 persons from 87 countries.

The two items on the agenda of the section on juvenile delinquency, were "New forms of juvenile delinquency: their origin, prevention and treatment" and "Special police services for the prevention of juvenile delinquency."

In regard to the first item the Congress concluded in brief that:

1. The meaning of the term juvenile delinquency should be restricted to violations of the criminal law and should not include offenses for which adults would not be prosecuted.

2. The questions of whether certain forms of delinquency are increasing and if so why, should be the object of study by the United Nations with the cooperation of specialized agencies and non-governmental organizations.

3. Diversified methods of prevention and treatment are required, including preparation of young people for release from institutions and postinstitutional assistance.

4. Study of "new" forms of juvenile delinquency should continue, and more intensive application should be made of experimental and conventional forms of prevention and treatment, including: (a) efforts by official agencies and committee groups to direct the energies of the young into constructive leisure time activities; (b) intensive studies of the social history of young offenders; (c) invigorated education both of adults and juveniles to increase the understanding and sympathy between them; (d) reasonable steps to reduce the effects of the "abuse of mass media" with sensational material and to stimulate the production of constructive films and literature.

In regard to police services the Congress concluded, in brief, that:

1. The police should not assume specialized functions that are appropriately within the field of social, educational, and other services.

2. The preventive action undertaken by the police should remain subordinate to the observance of human rights.

3. The report of the International Criminal Police Organization, "Special Police Departments for the Prevention of Juvenile Delinquency," represents a sound basis for the organization of such departments.

The Congress expressed "certain reservations" in regard to the finger printing of juveniles or to a police established system of awards or demerits.

It stressed the importance of cooperation between the police, specialized agencies, and the general public in efforts toward delinquency prevention.

—Philip G. Green

Federal Legislation

Under the 1960 amendments to the Social Security Act, passed by the 86th Congress before adjournment in September, the Children's Bureau is for the first time empowered to make grants directly to universities or agencies for research or demonstration projects in the field of child welfare. The authorization is included in a special section of title V, which also authorizes a separate appropriation, for which no ceiling is set, to be made for such grants. The grants can be made to public or non-profit institutions of higher learning or public or other nonprofit agencies or organizations engaged in research or child welfare activities.

The amendments also authorized the Bureau to make grants for special projects in maternal and child health and crippled children's services up to 12½ percent of the amounts appropriated for these programs, not only to the States, as is currently being done, but also directly to institutions of higher learning.

The amendments raised to \$25 million each the amounts that can be appropriated for all three of the programs administered by the Children's Bureau under the act. For crippled children's services this is \$5 million above the previous authorizations; for maternal and child health services it is \$3,500,000 above; for child welfare services, \$8 million above.

Appropriations made by the Congress for the year 1960-61 were \$20 million for crippled children's services; \$18,167,000 for maternal and child health; \$13,666,000 for child welfare services. No appropriation was made for grants for research or demonstration projects in the field of child welfare.

Child Welfare

According to a recent decision of the North Dakota Supreme Court, its State court has jurisdiction to terminate parental rights of an Indian couple over their minor children, upon proper cause, when neither parent is living on an Indian reservation even though each is enrolled as an Indian at a reservation. The court noted that the acts

School Desegregation

Sixteen school districts in seven States have begun school desegregation this fall, according to an announcement made by the Secretary of Health, Education, and Welfare, Arthur S. Flemming, late in September. The Secretary pointed out that figures made available to him by the Southern Education Reporting Service indicate that 325 more Negro students have been admitted to formerly all-white schools in Arkansas, Delaware, North Carolina, Oklahoma, Tennessee, Virginia, and Texas—including the city of Houston, which has had the largest segregated school system in the Nation. In addition about 100 Negro pupils are expected to be admitted to the first grade of New Orleans all-white schools.

Secretary Flemming urged that although this progress is encouraging, "it does not constitute any basis for com-

placency." He pointed out that 21 public schools in Prince Edward County, Va., padlocked by county officials a year ago to avoid compliance with a Federal-court desegregation order, remain padlocked. About 1,500 white children in this county receive education through private schools provided by a special foundation. Of the 1,700 school-age Negro children about 300 attend schools outside the county; for the rest the only educational facilities available are 16 "training centers" set up by some Negro groups. Calling these training centers a "praiseworthy effort," the Secretary said that "no one would contend that they are an adequate substitute for a normal educational program."

In other parts of Virginia, 11 school districts have begun desegregation, 5 of them this fall.

cited as grounds for the suit for termination, which was filed in the District Court of Burleigh County, took place not within the boundaries of an Indian reservation but within the territorial jurisdiction of the district court.

The court said: "We find no attempt on the part of Congress to deny recognition of the rule that State courts are open to all persons irrespective of race, color, or citizenship as applied to civil actions by or against Indians not residing on a reservation."

* * *

Development of psychiatric centers for "psychiatrically deviant children"—whether neurotic, psychotic, mentally deficient, or exhibiting character problems—is being recommended by the Group for the Advancement of Psychiatry. The centers would offer diversified programs including inpatient, day hospital, and outpatient services. Such centers, the Group maintains, would make available to the children the therapeutic skills each needs, regardless of the category in which he is classified. The center's first responsibility would be to provide comprehensive differential diagnosis. Then would follow development of a treatment plan based on the concept that the patient is first a child and secondarily a person with an abnormality.

Flexibility in age limits for treatment

facilities is also recommended by the Group, which points out that the differences between childhood and adolescence, and adolescence and adulthood, are often indistinct.

The recommendations are embodied in a report, "Basic Considerations in Mental Retardation—a preliminary report, formulated by the committee on mental retardation," available from the Group for the Advancement of Psychiatry, 104 East 25th Street, New York 10: 40 cents a copy.

* * *

One out of every 150 children under 18 in the Washington Metropolitan area in 1958 was living away from home under the supervision of a social agency, according to a report recently published by the Health and Welfare Council of the National Capital Area. The report, "Children Away from Home, Part I, a Staff Report," was prepared by Edward B. Olds. It presents the results of a census of children who were not living with their natural or adoptive parents or other relatives and who were in the care of 42 of the 44 child caring agencies serving the area and estimates of the numbers of children in the care of the two non-reporting agencies.

Of the 4,500 children away from home in the care of the 42 reporting

agencies, 2,791 were dependent and neglected, 962 were delinquent, 546 were mentally retarded, and 210 were emotionally disturbed. Fifty-eight percent of the children living away from home were nonwhite as compared with 27 percent of nonwhite children in the total child population. The data on terminations of care showed a considerably higher termination rate for white (78 percent) than nonwhite (21 percent).

Children on ADC

Less than 4 percent of the children under 18 in the United States were receiving public assistance through the Federal-State aid to dependent children program in December 1958, according to a report of a biennial survey of facts about families in the program recently issued by the Bureau of Public Assistance, Department of Health, Education, and Welfare. Among the facts about the 745,000 families, including 2,142,000 children, who were receiving such aid at that time the Bureau reports that:

- Six of every 10 families were white; 4, nonwhite.
- The children's median age was 8.4 years; 77 percent were under 13.
- Most of the children had been on the ADC rolls for a short time; the median was 2.1 years.
- Ten percent of the fathers were dead; 26 percent incapacitated. Among the other fathers, 5 percent were imprisoned; 13 percent were divorced or legally separated from the mothers; 8 percent were separated without a court decree; 19 percent had deserted; 16 percent were not married to the mothers.
- The families' average monthly income from all sources amounted to only 21 percent of the national per capita monthly income. In many States ADC payments were inadequate to meet the State's own standard for the families' financial requirements. Forty-eight percent of all the families in the program did not receive enough income to meet their needs; the average monthly shortage was nearly \$39.
- Fifty-five percent of the families had no income other than payments under public assistance programs. The others received income from various sources, averaging \$24 a month: in 13 percent, cash earnings of the mother; in 12 percent, money contributions from

absent fathers; in 6 percent, social insurance benefits.

- Families with the mother employed included 87,000 children under 6 years of age and 165,000 with children 6-12 years. Arrangements for care in the home or elsewhere while the mothers were working outside the home had been made for 89 percent of the children under 6 years and for 78 percent of those 6-12.

Radiological Health

Since last March the Public Health Service has increased from 10 to 59 the number of sampling stations for measuring radioactivity in milk. Coverage is now almost nationwide, with at least one sampling station in each of 47 States, the District of Columbia, and Puerto Rico.

Data from the sampling stations published by the Service in July showed that the average measurements of strontium-90 in milk, in micromicrocuries per liter, during the period February 1959 through January 1960, ranged from 3.4 for Overton, Nev., to 22.4 for Saint Louis, Mo. These averages, the Service points out, are well below the level of 33 micromicrocuries per liter or kilogram for water and for milk and other foods, recommended as a guideline by the National Committee on Radiation Protection and the International Commission on Radiation Protection. That level has been adopted as a radioactivity concentration guide by the Department of Health, Education, and Welfare pending completion of studies by the Federal Radiation Council, an advisory body established last year by President Eisenhower.

A serious deficit exists in the number of experts trained to cope with the public health and safety problems accompanying the rapidly expanding use of radiation of various kinds throughout the Nation, according to estimates made by the Public Health Service. For example, only 10 medical radiation physicists are being trained each year, though the estimated need in major hospitals and health agencies is for an increase of 100.

By 1970, according to the estimates, at least 4,000 additional physicians, engineers, and physicists, with extensive training in radiological health and protection measures, will be needed;

and to reach that number, the Nation's colleges and universities should be admitting annually at least 600 candidates for such training. Currently only about 200 are receiving it.

These estimates were presented at a 3-day symposium on the subject of personnel needs in this field called together by the Public Health Service in Princeton, N.J., last August. Participants representing the faculties of a number of colleges and universities expressed recognition of the urgency of the need and a willingness to work to meet it.

The Public Health Service itself has been conducting a series of short courses in radiological health during the past 10 years. Last year (1959-60) 386 persons from public agencies and private industry took these courses. About 600 are expected to take the courses this year and about 1,000 next year.

Financing Services

The Rockefeller Foundation has appointed an ad hoc committee of civic leaders, with a study director and a professional advisory staff, to make a year's exploratory study of the voluntary support of local, regional, and national health and welfare agencies.

The committee will look into such questions as:

- Are there criteria by which the public can evaluate the programs and operating methods of such agencies?
- What is the impact on private agencies of expanding governmental activities in health and welfare?
- Are research and professional education being adequately supported by voluntary agencies?
- Are there principles and methods of community planning that encourage cooperative efforts among private and governmental agencies?
- Is there a solution to the disagreement between agencies committed to federated fund-raising and those which raise funds independently?

Hospitals will be excluded from the scope of the study as having unique problems which have already been the subject of many special studies.

If at the end of the year's work the committee recommends further comprehensive study, it will make detailed proposals for examination of special problems and will suggest whether the

larger study should be conducted by the committee itself or by a new group.

According to the Foundation, philanthropic giving for health and welfare services, research, and education has nearly doubled within the past decade, reaching \$7.8 billion in 1959, while the governmental share of health and welfare financing has grown even more rapidly.

Against Polio

On the basis of recommendations by the Public Health Service's advisory committee on live-poliovirus vaccine, the Surgeon General on August 24, 1960, announced that the Sabin live virus vaccine is now considered suitable for use in the United States. The safety and effectiveness of the vaccine, which has had extensive field trials abroad and on a smaller scale in this country, have been under study by the committee for the past year. (See CHILDREN, September-October 1959, p. 194, and November-December 1959, p. 236.)

The vaccine, which can be taken orally, was developed by Dr. Albert B. Sabin at the University of Cincinnati. Recommendations which will form the basis for the manufacturing regulations have been drawn up by the advisory committee and will have legal status after they are published in the *Federal Register*.

The Public Health Service recently announced formation of a Surgeon General's Committee on Poliomyelitis Control, to be made up of representatives of the medical and health professions and the general public. The Children's Bureau is among the 23 agencies and organizations which have been asked to designate members to serve on the committee.

The group will meet in midwinter to consider the questions in relation to the administration of the live virus vaccine, such as how the use of the new vaccine can be integrated with the use of the presently available Salk killed virus vaccine, and whether or not the administration of the live virus vaccine would be more appropriate on a community than an individual basis.

White House Conference

At a meeting in Washington on September 19, the President's National Committee for the 1960 White House Conference on Children and Youth voted

to transfer the residual funds of the Conference to the new National Committee for Children and Youth, which has been set up to stimulate implementation of the Conference recommendations and widespread use of its materials. (See *CHILDREN*, September-October 1960, p. 196.) Officers of the new committee, elected in September, are: *Chairman*, Mrs. Thomas Herlihy, Jr., Delaware State Labor Commission; *vice chairmen*, Luther H. Foster, Tuskegee Institute, and Katherine B. Oettinger, Children's Bureau; *secretary*, Sylvia Carothers, Florida Children's Commission; *treasurer*, Lyle W. Ashby, National Education Association. Mrs. Isabella J. Jones, who was associate director of the White House Conference, has been appointed director of the new committee.

On October 10 the executive committee of the President's National Committee as its final action presented a specially bound copy of the Conference proceedings, just off the press, to the President of the United States.

The 429-page book has four parts and an appendix. Included are sections on the history and organization of the Conference, the program and exhibits, highlights from the Conference sessions, and the composite report of the forum recommendations which has already been published separately. In the section on the Conference sessions are the full texts of some major addresses, in-

cluding those of President Eisenhower and of Arthur S. Flemming, Secretary of Health, Education, and Welfare, and abstracts of all speeches from the forums and theme assemblies.

The proceedings are available from the National Committee for Children and Youth, Room 411 Association Building, 1145 19th Street, Washington 6, D.C. (Price \$2.60 including cost of mailing.)

A volume of selected papers from the Conference is soon to be published by Columbia University Press.

Miscellaneous

"International Society for the Rehabilitation of the Disabled" is the new name of the former International Society for the Welfare of Cripples. The name was changed at the Eighth World Congress of the society, which was held in New York, August 29-September 2, 1960, with some 3,000 delegates from 79 nations attending.

Representatives of parent cooperatives in 10 States, two Canadian Provinces, and the District of Columbia formed a national association, the American Council of Parent Cooperatives, at a meeting in New York City, August 22-23, 1960. Parent cooperatives include nursery schools, kindergartens, and other educational arrangements for pre-school children and their parents, operated by parents. The par-

ents work with trained teachers who are in charge of the children. Many programs of this type are being carried on across the country. Among the oldest are those in Seattle, Wash.; Baltimore, Md.; Long Beach, Calif.; and Montgomery County, Md.

Mrs. Roy Harkins, of Birmingham, Mich., is president of the new organization.

A new national citizens' organization, the National Family Life Foundation, was recently organized in New York to work toward unifying the many efforts now being made to preserve and strengthen family life in the United States. The group is planned as a central resource agency, carrying out and promoting research on family life, identifying needs not being fulfilled by existing programs in the field, recommending and sponsoring programs aimed at fulfilling those needs, acting as a clearing house for research results and other information, stimulating educational programs, and bringing together existing organizations in conferences. The foundation's president is Philip Mather of Boston; its headquarters, 225 West 57th Street, New York 19; its executive secretary, Conrad Van Hyning, who is also director of the American Social Health Association. The foundation is seeking support from philanthropic foundations, industry, and individuals.

Guides and Reports

AN INTERDISCIPLINARY APPROACH TO ACCIDENT PATTERNS IN CHILDREN. Irwin M. Marcus and others. Monographs of the Society for Research in Child Development, Vol. 25, Serial No. 76, No. 2. Child Development Publications, Purdue University, Lafayette, Ind. 1960. 79 pp. \$2.50.

Compares children who have had several accidents with enuretic children and with a control group in regard to psychological, physical, and intrafamily factors and to behavioral responses; finding many similarities between the

accident-prone and the enuretic children.

EMOTIONAL ASPECTS OF SCHOOL DESEGREGATION; a report by psychiatrists. Group for the Advancement of Psychiatry, 104 East 25th Street, New York 10. 1960. 48 pp. 50 cents. Discounts on quantity orders.

A condensed and less technical version—including new material—of a 1957 report, "Psychiatric Aspects of School Desegregation" (see *CHILDREN*, January-February 1958, p. 37),

this report examines the psychological effects of school segregation on children, parents, and teachers, as well as on the country and community; and discusses the origins of prejudice and possible ways of changing negative attitudes toward desegregation.

CHILD WELFARE LEAGUE OF AMERICA STANDARDS FOR SERVICES TO UNMARRIED PARENTS. The League, 345 East 46th Street, New York 17. 1960. 74 pp. \$1.50.

Presents standards for a number of types of professional services for unmarried parents—social casework and groupwork, medical and hospital, adoption, and other welfare and health services.

AID TO DEPENDENT CHILDREN IN LOUISIANA

IN early October the Commissioner of Social Security notified the Department of Public Welfare in Louisiana of a hearing to be held later in the fall to determine whether the State's program of aid to dependent children is in conformity with the requirements of the Social Security Act and so acceptable for continued Federal support. Under the variable formulas for State reimbursement, Louisiana has been receiving 75 percent Federal reimbursement for money expended on the program.

The notification followed the revision of the "suitable home" provision in the State's plan to conform with new State legislation—which resulted in about 22,500 children and 6,000 mothers being dropped from the rolls in mid-July.

The new State law, passed in June, prohibits payments under the aid-to-dependent-children program to families in which the home is unsuitable for a child and defines this as a home in which a man and woman are living as husband and wife without being legally married. It also requires assistance to be discontinued if the mother has had an illegitimate child after she has received an assistance check—no matter how long ago that was—until the parish (county) welfare board finds that she has ceased illicit relations and is now maintaining a suitable home.

The same legislature in another act made it a criminal offense to enter into a common-law marriage or to produce two or more children out of wedlock.

ABOUT 90 percent of the 22,500 children were dropped from the rolls because the mothers had given birth to an illegitimate child after receipt of assistance. In all dropped cases assistance was denied to all children in the case. School children in many of these families are not receiving free school lunches.

Under the State law, to have assistance reinstated the mother must re-apply and have a determination of suitability made by the parish welfare board. The agency has ruled that placement of the children in suitable homes of other relatives will not make a child

eligible for aid to dependent children.

About 540 cases had been reinstated by September 14, and about one-half of the cases would be reinstated by November, according to the State welfare agency.

Early in September the director of the Bureau of Public Assistance asked the Louisiana Department of Welfare for a report on its actions in regard to these children, pointing out that "to deny assistance . . . to children who have already been determined to be needy without making provision for their maintenance and care seems to run counter to the type of responsibility placed in State welfare departments for the protection of children." The State agency was asked to describe the steps being taken to protect "the large numbers of children purportedly living under conditions so unsuitable that the State feels impelled to withdraw from them sufficient aid to provide the necessities of everyday living." The letter also asked for assurances on a number of specific issues having a bearing on conformity with Social Security Act requirements.

THE Commissioner's notification of the impending hearing pointed out that the State's reply to the communication from the Bureau of Public Assistance had left many serious questions unresolved. Four which it specified were, in brief: (1) whether the State is in conformity with Federal requirements in automatically dropping one-fourth of the ADC cases from the rolls, even though more than one-half are expected to be eligible upon reapplication; (2) whether the State plan provides an opportunity for a fair hearing to families dropped from the rolls; (3) whether recipients have been dropped from the rolls without proper determination of their ineligibility, based on current facts; (4) whether the State requirements which resulted in these terminations were designed to deprive needy children of aid "solely because of the conduct of a caretaker relative which the State has found to be offensive, but not necessarily of adverse effect to the children."

In the meantime some local and na-

tional groups were making efforts to meet the emergent needs in families left destitute by the withdrawal of aid. In New Orleans, where 5,300 of the children lived, the city made \$4,000 available for emergency assistance. The local Urban League led a drive to secure voluntary funds, largely through churches, for emergency aid. A statement issued by the League in late September reported that its offices were beleaguered by hungry women and children seeking money for food, medical supplies, and rent, and that many of them had been evicted from their homes.

THE National Urban League, in initiating a nationwide drive for funds, pointed out that in Louisiana areas outside New Orleans "there were practically no rescue facilities because of total lack of organizational structure that might aid Negroes." About 95 percent of the children dropped from the rolls are reported to be Negroes.

Indications that the situation was also receiving international attention came when \$400 worth of free baby food labeled "Bundles from Britain" was sent to Louisiana by a group of city councilwomen in Newcastle, England.

In communications sent to the Secretary of Health, Education, and Welfare late in September, the Committee on Social Policy of the National Social Welfare Assembly and many of the Assembly's member agencies urged the Federal Department to adhere to the general policy that a home is suitable for receipt of assistance until a court decision has removed the children.

In 24 States the ADC programs carry some reference to the responsibility of the agency to see that children are in suitable homes, according to a report recently issued by the Bureau of Public Assistance, "Illegitimacy and its Impact on the Aid to Dependent Children Program." In 18 of these the State continues assistance until the home meets the test of suitability or until other arrangements have been made for the children. In six, the State plans deny assistance without assurance that an arrangement for the child's upbringing is worked out.

IN THE JOURNALS

Support of Orphans

An estimated 86 percent of United States children whose fathers die are awarded benefits each year under the old-age, survivors, and disability insurance provisions of the Social Security Act, according to a report in the *Social Security Bulletin* for September 1960. ("Money Income Sources of Young Survivors, December 1959," by Mollie Orshansky.) At the end of 1959 about 12 percent of such paternal orphans were receiving benefits under more than one public income maintenance program, usually both OASDI and veterans' compensation or pension payments.

Public assistance, in the form of aid to dependent children, provided income in 1959 for 225,000 children whose fathers were dead, the article states—about 11 percent of the total. An estimated 95,000 of these—about 40 percent—were also beneficiaries of social insurance or related programs.

Of the 740,000 widowed mothers who in 1959 had children under 18 in their care, 395,000 were receiving support from social insurance and related programs and 75,000 from federally aided public assistance; 30,000 received payments from both sources.

More than half of all the widowed mothers had employment during 1959, but 40 percent of those who worked also received payments from some type of public program. Among divorced or separated mothers with children under 6, the proportion working was one-third again as high as among widows with children in the same age group.

Management of Epilepsy

A child who has had one epileptic seizure, especially a teenager, is likely to suffer greatly from fear of having a second one and should be treated immediately in an effort to prevent recurrence and to relieve emotional disturbance in him and in his parents, says Samuel Livingston, M.D., in the *Journal of the American Medical Association* for September 10, 1960. ("Man-

agement of the Child With One Epileptic Seizure.")

Emotional disturbances in epileptic children and their parents are sometimes a greater problem than the seizures, says the author, who is director of the epilepsy clinic at Johns Hopkins Hospital. He adds that much harm may be incurred by both child and parents if no attempt is made to prevent the recurrence of an unquestionable epileptic seizure. Noting that some seizures are not classified as epileptic, he points out that his recommendation for immediate and prolonged treatment depends on the diagnosis of the individual child.

The author reports a considerable reduction of recurrences of seizures in patients at his clinic since the program of administering prolonged anticonvulsant therapy to children who have had one seizure was introduced 9 years ago.

Circular Residences

In *Hospitals*, journal of the American Hospital Association, for September 1, 1960, a nurse and an architect join in proposing an experimental plan for a residence unit for emotionally disturbed children, constructed in the form of a circle, "traditionally a symbol of warmth, closeness, and protection." ("Living in a Circle; a proposal for a residence for disturbed children," by Gladys M. Hillsman and Paul D. Spreiregen.) The unit described is planned as an annex to an already established children's hospital. A separate school unit, also circular, is included in the plan. The authors explain that going to school outside the residence unit would lessen children's feeling of being hemmed in.

When the child first approaches the residence with his parents, the authors maintain, a circular unit, instead of reminding him of a school, a hospital, or a courthouse, where he may have been unhappy, is likely to remind him of a tent, perhaps a circus tent. Later, when his bedroom is one of a number arranged around a central office, he can be observed by the staff without loss of

privacy; also, he will feel less deserted by adults if he can lean over in bed and see that a staff member is near, but, the authors add, "not too near."

The Emotionally Disturbed

Pointing to the fact that improvement of emotionally disturbed children depends largely on improvement in family relationships, Joseph J. Reidy, M.D., in the *Southern Medical Journal* for September 1960, notes types of interaction between child and parents at various stages of childhood which may cause disturbance in the child. ("The Emotionally Disturbed Child; problems within the family.")

In the diagnosis and treatment of such children, the author, a child psychiatrist, urges that more emphasis be placed on knowing about the family unit and on recognizing that concepts of normal and abnormal behavior in adults do not apply to the child, whose personality is developing.

Furthermore, he urges that no child be removed from his own home until all resources and skills have been used to mend the family, or unless the child shows a specific need requiring placement out of the home, such as a need for experience in corrective group living, for gaining better relations with authority figures, or for gaining mastery over his impulses.

Adoption Practices

Misunderstandings concerning agency adoption procedures, and principles and guidelines for adoption practice, are discussed by Ross T. Wilbur in *Iowa Public Welfare in Action*, Summer 1960.

Among widely believed "myths" discussed by the author are: that many children in institutions are available for adoption; that agencies' screening of applicants for a child is arbitrary; and that the interests of the medical, law, and social work professions conflict in the adoption field. Some of the myths, he suggests, are encouraged by inadequate explanations by the agencies concerning their practices.

The author sets forth guidelines for adoption practices based on protecting the rights of the child, of the natural parents, and of the adoptive parents, and he adds that there is little doubt that the public at large subscribes wholeheartedly to practices based on those principles.

READERS' EXCHANGE

GOLDBERG: *Lawyers and Social Workers*

Harriet L. Goldberg's presentation of the community of interests and needs of social workers and lawyers is a helpful consideration of a longstanding problem in relationships, and her treatment of some particularly vexing problems in the adjudication process should be of value to lawyers and social workers alike. ["Social Work and Law," by Harriet L. Goldberg, *CHILDREN*, September-October 1960.] It is indeed encouraging to read her documentation of a dozen or more movements toward increased collaboration and mutual respect between these two professions.

It could have been emphasized, however, that the largest area of misunderstanding, if not actually antagonism, concerns the respective roles of lawyer and social worker in the adjudication process. While the social worker is not alone responsible for this misunderstanding he can at least contribute responsibly to a resolution of it by gaining an understanding and appreciation of the nature and function of the legal process. If he is to play a part in this process, he would do well to gain a degree of understanding sufficient to clarify and identify his own special role. The deeper his understanding and appreciation, the sharper and clearer his role, the more rapidly will there be achieved a resolution of the misunderstandings and conflict.

The social worker can take some comfort, however, in the fact that he is not alone with this problem. He has notable companions in the physician and the psychiatrist. An attorney might welcome all three on many occasions, but he generally is apt to consider them a problem in the courtroom. He would, on the other hand, certainly welcome a social worker who appreciated the hard-won elements of due process and who contributed to the adjudication process within the framework of the law's methods and objectives.

Miss Goldberg has done such a nice job in setting forth the meaning of a "fair hearing" and in considering the complexities of the "social study," I

trust she will find it possible to prepare a series of articles which detail other parts of the legal process as a further contribution toward enhancing the social worker's understanding.

C. Wilson Anderson

Commissioner, Office for Children and Youth, Pennsylvania Department of Public Welfare, Harrisburg.

BRADWAY: *Perceptible Improvements*

In his article in the September-October issue of *CHILDREN* John S. Bradway brings us face to face with the many facets of the problems involved in family law. ["A Suggestion for Improving Family Law," by John S. Bradway, *CHILDREN*, September-October 1960.] His concept of a group of "nonspecialized but trained individuals," who might be in a position "to fit the innumerable pieces of the gigantic jigsaw puzzle of family law together" is an intriguing one.

It occurs to me, however, that it is because lawyers and social workers are beginning "to see across" their respective professions that progress is being made in the field of family law—glacial progress perhaps, but nonetheless perceptible. Mr. Bradway himself for many years has bridged the gap between these two professions.

The recent Standard Family Court Act was prepared by a committee of the National Probation and Parole Association (now the National Council on Crime and Delinquency) in cooperation with the National Council of Juvenile Court Judges and the Children's Bureau. Included were judges, lawyers, social workers, correctional workers, and public welfare administrators.

The Committee on Lawyer-Family Agency Cooperation of the Family Service Association of America and the new Family Law Section of the American Bar Association, which Mr. Bradway mentions, are other evidences of interest at the national level in the improvement of family law.

Some State and local bar associations also have established committees in family law. Important changes in procedures in desertion and nonsupport

cases in Allegheny County, Pa., are being made as a result of joint activity by committees of the county bar association and the local health and welfare association.

The behavioral science center at Stanford University, the law and behavioral science fellowships at the University of Chicago, the institute on family law held in 1959 at Duke University, are all examples of the recognition today of the need to pool the knowledge of the various disciplines.

Almost 40 years ago Roscoe Pound, then dean of the Harvard Law School, said that when we look at the core of the different organized bodies of knowledge that treat of different aspects of social life, the analytical distinctions are sound enough, "but we shall not understand even that core, and much less the debatable ground beyond, unless we are prepared to make continual deep incursions from each into each of the others. All the social sciences must be coworkers, and emphatically must be coworkers with jurisprudence."

Mary T. Denman

Attorney at Law, and Consultant on Public Welfare, Pennsylvania Citizens Association for Health and Welfare, Pittsburgh.

BOGGS AND NORDFORS: *Author's comment*

There was one omission relating to the article by Mr. Nordfors and myself which I hope may be somehow rectified. ["Care of the Mentally Retarded in Sweden," by Elizabeth Boggs and Gösta Nordfors, *CHILDREN*, July-August 1960.] It was a United Nations fellowship which enabled Mr. Nordfors to make an extensive tour of the United States in 1956; it was during this tour that he and I met and talked at length about the new Swedish law; out of these conversations grew our article. It might also be worth noting that Mr. Nordfors was a member of the special legislative commission, chaired by a member of the Swedish Parliament, which worked for several years to develop the comprehensive law, enacted in 1954.

We agree with Lewis A. Dexter that there may be wide gaps between legislative prescription and practice. [See Readers' Exchange, *CHILDREN*, September-October 1960.] I had a chance this past summer to observe some of the advances Sweden has made in prac-

tice since 1954. It is too early to evaluate all aspects.

I am sorry that we did not make clear to Mr. Dexter that the *annual* registration (census) lists all citizens, not all defectives as such. An accounting of school status of school age children is a byproduct. "Registration" as a retardate is a separate process with emphasis on clinical evaluation and need for service rather than on statistical completeness or IQ cutoff point. Since the slow learners and high "educable" retardates are not included, Swedish authorities estimate that less than 1 percent of the population will qualify for the program described in our article.

Elizabeth Boggs

President, National Association for Retarded Children, New York

Other programs for the retarded

The comparison of programming for the mentally retarded in different countries is always difficult, since the culture, habits, and social customs vary enormously. As Mrs. Boggs and Mr. Nordfors have pointed out in their article about Sweden's program, each area develops a program which is fundamentally suited to its population and environmental needs.

In Great Britain, the national Government has now assumed responsibility for the care of all retarded, and has subdivided this responsibility to regional boards. Care is free. Day centers for training and education, and sheltered workshops are provided. There are halfway houses and "homes" for groups of workers.

In Canada, as in Sweden, there are provinces. These provinces vary in their overall size and population numbers, but are responsible for the care of their own mentally retarded.

In Saskatchewan a system of work-home placements has been established. These are controlled from the central residential school by its psychiatric social workers. Foster home placements are arranged by the school and are the responsibility of the school. Placements in such homes are from the school only, and no placement can be made directly from the child's own home. Cluster placements are found to be of most value since they make the break from the central school less difficult.

An IQ level of 75 or below is con-

sidered in Saskatchewan to mean retardation. For those above this level, but still below average, special classes are available in the public school system. In Britain the IQ level is not the overriding factor. Persistent social problems are considered an indication of deficiency requiring special training and education.

A. J. Beddie

Superintendent, Saskatchewan Training School, Moose Jaw, Saskatchewan, Canada

WAITE: Social action process

Miss Waite's article on the process followed in Wisconsin to secure a law authorizing the State welfare department to establish a residential treatment center for emotionally disturbed children illustrates the effective bringing together of many professional and voluntary interests concerned with the welfare of children. [See "Winning a Victory for Emotionally Disturbed Children," by Dorothy Waite, *CHILDREN*, September-October 1960.] The process of securing such interdisciplinary and public-private agency cooperation takes time. The proper treatment of emotionally disturbed children concerns too many agencies for short cuts to be possible.

It is surprising to read that at the last minute the State university's medical school raised questions about vesting the administration of the new center in the State welfare department. Apparently, the medical school was not a party to the original planning although it was interested in having such a center for training personnel and for research. This situation exists in many places and deserves more study. Administrative agencies are needed to handle State service programs. A medical school cannot give complete coverage of service where needed, but has to select the cases to be served on the basis of clinical material for teaching and research purposes. Since we need both more trained specialists and more skillful services from the State government, more attention must be given to ways of achieving both.

The lesson learned in Wisconsin from not using the legislative council at the very beginning of the attempt to secure the treatment center is also important for social workers. The eventual resort to a 2-year study involving the active participation of several key legis-

lators and influential citizens was excellent. The welfare department's frank presentation of the unpleasant matter of high costs must have inspired faith in its integrity. Surely the sponsors will not be expecting magic, but only moderate results after much hard work.

The last-minute difficulty in securing the bill's passage, which occurred when the difficulty with the medical school arose, indicates that legislatures will not be used to settle disputes or differences in philosophy of administration between several State departments.

While the article mentions the fact that the State education department participated in the social action efforts, the role it played does not become clear.

Similarly, what was the participation of county officials in the developments? This is not mentioned. The district clinics will require county payments, and counties would probably be sharing expenses more willingly after taking part in the study and in efforts to pass the bill.

I would also like to know more about the structure that operated the publicity and lobbied for the bill. Apparently the Wisconsin welfare department has a standing advisory committee free from political and administrative responsibility. Did this committee become the central channel for promoting the bill? Was mail to and from citizen organizations routed through it? Did it supply the staff time and money needed for coordinating the efforts of so many organizations?

A State department seeking a major expansion of its services opens itself to the charge that it wants to aggrandize its position and secure more authority over local governments, if it does more than supply and interpret the facts behind its recommendations. Citizens who will not be directly involved in operating a new program are essential in the efforts to secure the necessary legislation.

Esther L. Immer

Executive Secretary, Iowa Commission on Children and Youth, Des Moines, Iowa

Photo Credits

Frontispiece, *Luomo Photos*, Wierton, W. Va.

Page 220, *Bekterev*, Institute, Leningrad.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

JUVENILE DELINQUENCY—FACTS,

FACETS: 7. Coordination of the National Effort for Dealing with Juvenile Delinquency—Governmental Responsibility, Bjarne Rommes, 17 pp., 15 cents; 8. Current Training Needs in the Field of Juvenile Delinquency, Bernard Russell, 16 pp., 15 cents; 9. How Effective are Services for the Treatment of Delinquents? Paul Schreiber, 22 pp., 15 cents; 10. Comparison of Expenditures and Estimated Standard Costs for Selected Juvenile Delinquency Services, 48 pp., 25 cents; 11. Delinquency and the Adolescent Crisis, Helen L. Witmer, 7 pp., 15 cents; 12. State Agencies and Juvenile Delinquency, Helen R. Jeter, 42 pp., 20 cents; 13. Staff and Training for Juvenile Law Enforcement in Urban Police Departments, Bernard Greenblatt, 42 pp., 20 cents; 14. Community Programs and Projects for the Prevention of Juvenile Delinquency, Mary B. Novick, 12 pp., 15 cents; 15. Survey of Probation Officers, 1959, Gladys M. Krueger, 24 pp., 15 cents; 16. A Survey of Sociological

Instructors Who Teach Undergraduate Courses in Corrections, Howard E. Fradkin, 10 pp., 15 cents. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, 1960.

These are the last 10 of the projected series of documents on juvenile delinquency addressed to a technical audience. The first six were noted in the May-June 1960 issue of *CHILDREN*.

Number 7 presents some of the problems involved in accomplishing effective coordination—administrative, inter-agency, and citizen participation—at local, State, and Federal levels.

Number 8 reviews training needs for personnel for delinquency treatment and prevention and recommendations for the establishment of effective interdisciplinary relationships.

Number 9 reviews selected studies, reports, and projects concerned with the effectiveness of services and suggests need for more frequent and comparable evaluative studies.

Number 10 presents results of study

of existing expenditures and estimated standard costs in different sections of the country for the four types of services—police, detention, probation, and training schools—indicating program and dollar deficiencies in each.

Number 11 reviews some of Erik H. Erikson's theories about adolescents as possible bases for action research in relation to delinquency.

Number 12 summarizes reports from 52 State public welfare departments regarding the nature and extent of each State's legal responsibilities, functions, and operation in the control of juvenile delinquency.

Number 13 reports on information obtained in a nationwide survey from 573 urban police departments regarding the adequacy of staff for specialized juvenile units, the educational requirements for appointment to them, and the provision of training programs for recruits and juvenile officers.

Number 14 reports on the results of a survey of activities, sponsored by community councils and other community groups, designed specifically to prevent juvenile delinquency.

Number 15 presents, among other facts, information on probation officers' education, salaries, and length of employment, obtained from questionnaires sent to a selected group of 502 courts.

Number 16 reports on the past experience in the correctional field of 218 sociologists teaching undergraduate specialized courses in corrections.

CHILDREN is published by the Children's Bureau 6 times a year, by approval of the Director of the Bureau of the Budget, September 3, 1959.

NOTE TO AUTHORS: Manuscripts are considered for publication with the understanding that they have not been previously published. Appropriate identification should be provided if the manuscript has been, or will be, used as an address. Opinions of contributors not connected with the Children's Bureau are their own and do not necessarily reflect the views of *CHILDREN* or of the Children's Bureau.

Communications regarding editorial matters should be addressed to:

CHILDREN
Children's Bureau
U.S. Department of Health, Education, and Welfare
Washington 25, D.C.

Subscribers should remit direct to the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C.

CHILDREN is regularly indexed by the Education Index

UNITED STATES GOVERNMENT PRINTING OFFICE, WASHINGTON 25, D.C., 1960

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C.

Price 25 cents a copy. Annual subscription price \$1.25

50 cents additional for foreign subscriptions

UNITED STATES
GOVERNMENT PRINTING OFFICE
DIVISION OF PUBLIC DOCUMENTS
WASHINGTON 25, D.C.
OFFICIAL BUSINESS

PENALTY FOR PRIVATE USE TO AVOID
PAYMENT OF POSTAGE, \$300
(GPO)

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Published
6 times
annually
by the

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ARTHUR S. FLEMMING, *Secretary*

SOCIAL SECURITY ADMINISTRATION • CHILDREN'S BUREAU

William L. Mitchell, *Commissioner*

• Katherine B. Oettinger, *Chief*

